Poppies & Pills in the Golden Triangle

The Resilience of the Asian Drugs Market and the Failure of Prohibitionist Policies

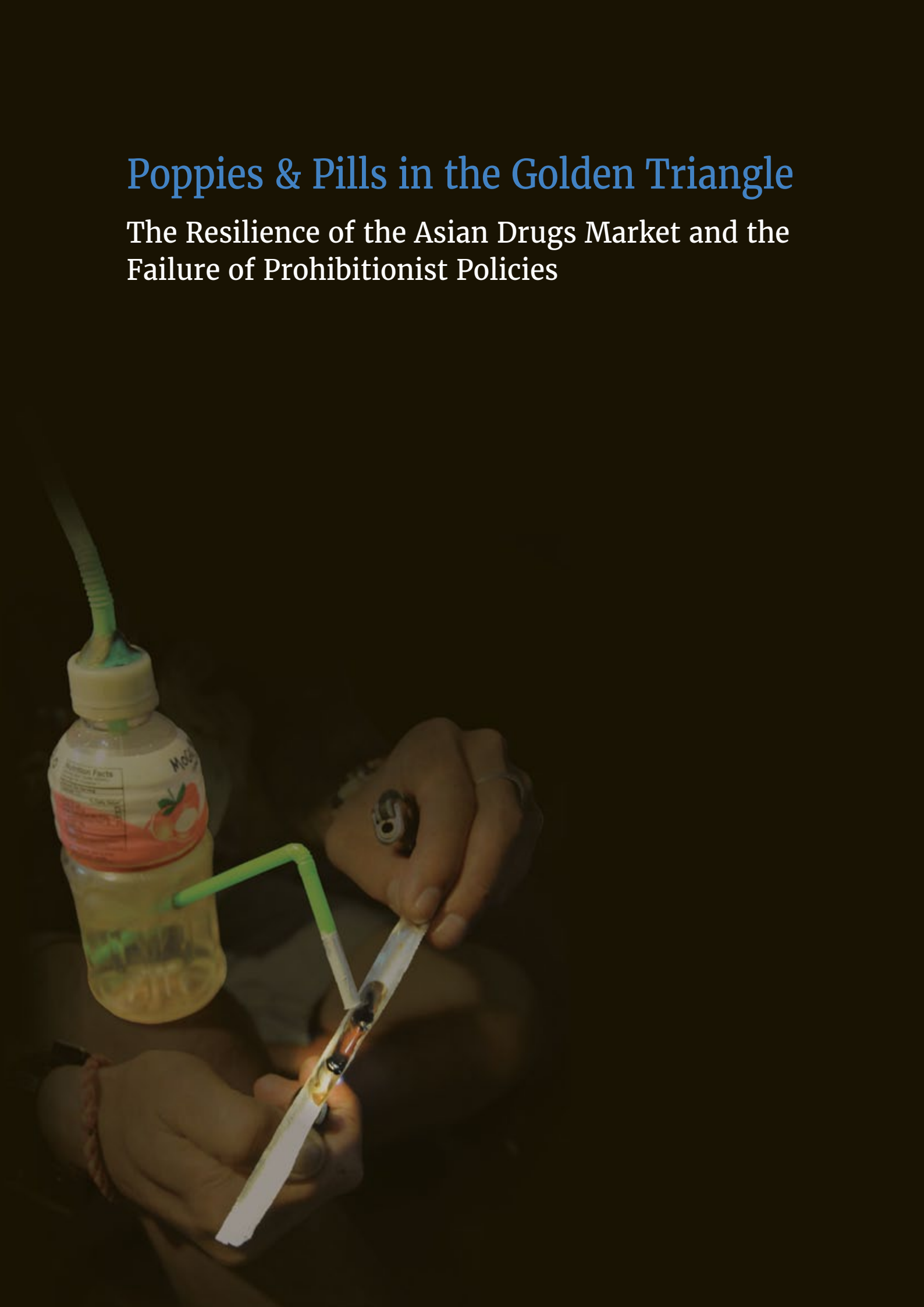

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Table of Contents

Map: Myanmar and Neighbouring Countries 5

Abbreviations 6

1 Introduction 8
Methodology and limitations 10

2 The Resilience of the Opiate Market in the Golden Triangle 12
Global opium cultivation and production trends 11
Opium cultivation and use in Kachin State and Sagaing Region 14
Estimating opium cultivation: data sources and limitations 16
Figure 1: Global opium cultivation 1998-2024 17
Opium taxation practices in Myanmar 18
Opium cultivation in Afghanistan 19
Impact of the Taliban Opium Ban 21
Opium cultivation in Southeast Asia 21
Table 1: Opium cultivation and production in Afghanistan and Myanmar 2017-2025 22
Resurgence and resilience of opium cultivation in Myanmar 23
Ex-poppy farmers speak - The impact of the Kokang and Wa opium bans 24
Opium cultivation trends in Myanmar 26
A male poppy farmer from Kanpaiti in eastern Kachin State speaks 26
Figure 2: Farm-gate opium prices in Southern Shan State 2011-2026 (MMK per viss) 28
Figure 3: Farm-gate opium prices in Eastern Shan State 2011-2026 (MMK per viss) 29
Opium and heroin consumption in Asia 30
Addressing environmental concerns in the context of drug cultivation 31
Recreational and medicinal opium use in the region 34
The heroin epidemic in Myanmar 35
Anti-retroviral treatment (ART) under threat in Myanmar 37
Table 2: Decreasing heroin prices in Lashio 2020-2024 38
Table 3: Opium, heroin and yaba prices in Hopin 2013-2023 (in MMK) 40
Unintended consequences of eradication of poppy fields in Kachin State 41
Table 4: Opium, heroin and yaba prices in Indawgyi 2019-2023 (in MMK) 41
Dilemmas around development-oriented drug policies 44
Heroin decline in China 45
Fentanyl and public health crises in North America 48

3 The ATS Boom and Diversification of Synthetic Substances 50
What are amphetamine-type stimulants (ATS)? 52
ATS Production 53
Drugs and Scam Centers in the Golden Triangle 55
Measuring the expansion of the ATS market 57
New Markets: ATS trafficking from Myanmar into Bangladesh 61
Availability and affordability 66
Poverty, marginalisation and involvement in drug markets 68
Methamphetamine use in different contexts 70
Gender, age, and stigma 71
Perceptions of health and other risks from ATS use 73

Figure 4: Drugs ordered by their overall harm 74
Self-regulation and harm reduction 75
Testimonials on buying and selling in Thailand and Myanmar 76
Chemsex experiences 78
Other synthetic substances 79
Impact of drug policies on individuals and communities 80
Experience of a 32-year-old man who uses drugs in Thailand 81
Diversifying strategies for diversifying drug markets 81
The Thai Narcotics Code and the resurgence of prohibitionism 82

4 Cannabis in Southeast Asia: Between Tradition and Reform 84
Cannabis use in Southeast Asia 84
Government data and policies 87
Cracks in the ASEAN drug consensus? 89
Medical cannabis in Southeast Asia: Trends in advocacy, policy, and discourse 90
Cannabis in Thailand 92
Cannabis as medicine in Southeast Asia: Past and futures 93
Mixed reactions 95
Cannabis in Thailand at a crossroads? 95
A brief overview of key cannabis developments in the wider Asian region 97

5 The Kratom Paradox: Trade and Prohibition in Southeast Asia 98
Kratom in Indonesia 99
Kratom: More than a psychoactive plant? 100
Kratom in Thailand 101
Kratom, health, and well-being 103
Kratom in Myanmar 104
Kratom in Mon State 106
Kratom cocktails and stigma 107
Kratom policy dilemmas at the international level 109

6 Discussion and Conclusion 110
The inevitable political nature of drug market studies 110
The resilience of drug markets in times of COVID-19 and beyond 111
Diversifying needs for harm reduction in Southeast Asia 113
Prevailing inequalities and injustices 114
State sanctioned and extrajudicial killings as disproportionate punishment 115
Drugs and conflict 116
Challenging the dominant "drugs and conflict" narrative 116
Drug policies of local authorities and communities 117
Myanmar as a case in point 119
Experiences of sex workers who use drugs in Myanmar 120
Drugs and Peace 122

Final conclusion and recommendations 123

Endnotes 126

Map: Myanmar and neighbouring countries



List of Abbreviations

AA	Arakan Army
AD	Alternative Development
APCOM	Asia Pacific Coalition on Male Sexual Health
ARSA	Arakan Rohingya Salvation Army
ART	antiretroviral therapy
ASEAN	Association of Southeast Asian Nations
ATS	amphetamine-type stimulants
BGF	Border Guard Force
CBD	Cannabidiol
CCDAC	Central Committee for Drug Abuse Control
CCTV	closed-circuit television
CND	Commission on Narcotics Drugs
COVID-19	Coronavirus disease
DKBA	Democratic Karen Buddhist Army
EAO	Ethnic Armed Organisation
EUDA	European Union Drugs Agency
ECDD	Expert Committee on Drug Dependence
FDA	Food and Drug Administration
GBH	Gamma-hydroxybutyrate
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HCV	Hepatitis C Virus
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
ICG	International Crisis Group
IDP	internally displaced person
IDU	Injecting Drug User
KTV	Karaoke Television
LGBT	lesbian, gay, bisexual and transgender
LGBTQ	lesbian, gay, bisexual, transgender, and queer
LSD	Lysergic acid diethylamide
MDM	Médecins du Monde
MDMA	3,4-Methylenedioxymethamphetamine
MMK	Myanmar Kyat
MMT	methadone maintenance therapy
MNDAA	Myanmar National Democratic Alliance Army
MOFF	Myanmar Opium Farmers' Forum

MSM	men who have sex with men
MTA	Mong Tai Army
NDAA	National Democratic Alliance Army
NDA-K	New Democratic Army-Kachin
NGO	non-governmental organisation
NNB	National Narcotics Board (Indonesia)
NNCC	National Narcotics Control Commission (China)
NMSP	New Mon State Party
NSP	needle and syringe programmes
NTFP	non-timber forest products
OAT	opioid agonist therapy
ONCB	Office of the Narcotics Control Board (Thailand)
P-2-P	phenyl-2-propanone
PDF	People's Defense Forces
PrEP	Pre-exposure prophylaxis
PWID	people who inject drugs
PWUD	people who use drugs
RCSS/SSA South	Restoration Council of Shan State / Shan State Army South
SAC	State Administration Council
SDU	sexualised drug use
SEZ	Special Economic Zone
SPDC	State Peace and Development Council
SSPP/SSA North	Shan State Progressive Party / Shan State Army North
STI	sexually transmitted infection
THB	Thai Baht
THC	Tetrahydrocannabinol
TNI	Transnational Institute
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	UN General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
ULA/AA	United League of Arakan/Arakan Army
US	United States
USAID	United States Agency for International Development
UWSP	United Wa State Party
WFP	World Food Programme
WHO	World Health Organisation



Incising opium pod in northern Myanmar (SKT)

1. Introduction

In the past decade, illegal drug markets in Southeast Asia and around the world have continued to expand and diversify, with key shifts in production, distribution and policy patterns. Synthetic drug production and consumption – particularly amphetamine-type stimulants – have both risen sharply. Opiates remain popular in some Southeast Asian countries, serving as a psychoactive substance, a traditional medicine and a source of income for impoverished rural communities. Meanwhile, Thailand became the first country in Southeast Asia to develop legal and decriminalized cannabis and kratom markets, radically departing from the zero-tolerance approach that still dominates the region.

The Covid-19 pandemic and various global developments – from growing geopolitical instability and rising socioeconomic inequality to the worsening climate crisis – have undoubtedly impacted drug markets as well. However, illegal drug markets remain highly adaptive, continuing to expand in size and diversity despite ongoing enforcement efforts worldwide, including in Southeast Asia. As such, drug market dynamics are inseparable from policy patterns. Market forces and policy responses continually shape one another, together affecting people and communities.

As documented in the TNI reports "Withdrawal Symptoms" (2009) and "Bouncing Back" (2014), prohibition-based policies have failed to address structural inequalities; this report examines how these dynamics have since evolved. Building on earlier publications[1], this report documents changes in drug markets in Southeast Asia and the wider region and analyses how they interact with social, economic, and political dynamics. Whilst it is crucial to document and respond to the harms associated with drug markets, one must also recognise people and communities who depend on these markets for survival, especially where legal and viable livelihoods are lacking. Having said that, this report deliberately refrains from problematising and pathologising language, aiming instead for a realistic

description and analysis of drug markets and their consequences, especially regarding the welfare and well-being of local communities affected by them. In this regard, indicators such as health, welfare, and human rights are put at the forefront and given primacy over quantitative indicators such as drug and precursor seizures.

When analysing drug markets in Southeast Asia, it is also essential to be critical of prevailing – and in some cases increasingly harsh and unjust – policies and their impact on communities. These policies concern not only drugs, but also land, gender, labour, and other interconnected issues. This is why this report focuses on the experiences and voices of communities, highlighting intersectional factors that increase vulnerability while concentrating power and wealth among a few.

Research for this report began shortly prior to the Covid-19 pandemic but was delayed by the global health crisis and, in Myanmar, the military coup of 2021. While these events slowed down data collection, the pause also allowed for deeper reflection and engagement with communities on their effects. Researchers conducted dozens of interviews and field observations between 2019 and 2024, creating a richer body of evidence over time.

This report takes a qualitative approach, prioritising lived experiences over statistics such as prevalence or seizure volumes. It draws on interviews and analyses gathered by trusted partners and organisations in Myanmar, Northeast India, China, Thailand, Bangladesh, and to a lesser extent Indonesia and Vietnam. These contributions highlight the diversity and complexity of communities involved in or affected by drug markets, particularly those ignored in mainstream narratives.

This report does not offer absolute truths but rather seeks to contribute to ongoing debates on drug policy and social justice in Southeast Asia and the surrounding region. It does not claim a monopoly on expertise but aims to raise critical questions about whose interests current policies serve and at what cost. In addition to insights into drug market dynamics, the report puts forward proposals for policy and data collection that place social justice at their core. These include frameworks to support community well-being, reduce harm and uphold human rights - while acknowledging the structural barriers to turning such principles into reality.

The data gathered for this report confirm a clear trend: drug use prevalence in Southeast Asia is rising, as it is elsewhere in the world, despite massive enforcement spending and Covid-19 restrictions. While drug use has become more accepted in certain age groups and professions, people who use drugs still face stigma and criminalisation. There is an increasing diversification of drugs on the market, and social, economic and cultural circumstances are determining the drugs of choice. At the same time with the rising drug use prevalence in Southeast Asia more and more people are incarcerated, especially the number of female prisoners has been rising



Girl harvesting opium in Wa region (TNI)



Valley with poppy fields in southern Shan State (TNI)

steadily over the past 5 years.[2] According to the UNODC 2025 World Drug Report, "the criminalization of drug use and resulting incarceration of people who use drugs or have drug use disorders have high costs, both direct and indirect, for individuals, their families and the community."[3]

It is a positive development that Thailand has reviewed its drug legislation and decriminalised cannabis and kratom, despite regularly returning risks of re-criminalisation with each change in government. The decriminalisation is viewed critically by some ASEAN member states, while Malaysia has shown interest in following Thailand's path. Meanwhile, knowledge of harm reduction as a self-help strategy is increasing, and conscious self-regulation of use is gaining ground.

Methodology and limitations

This report is based on qualitative interviews, field observations, and reviews of secondary sources. The interviewees included people who use and trade drugs, farmers, harm reduction advocates, NGO workers, journalists, and community leaders, and many were approached through local civil society organisations.

Dozens of interviews and focus group discussions were carried out between 2020 and 2024, involving a total of 177 respondents, including 75 from Myanmar, 15 from Thailand, 6 from Southern China, and 81 from Northeast India.

The report also draws on official publications from governments, NGOs, UN agencies, and academic researchers, providing a multi-perspective view of drug market and policy developments across the region, with particular emphasis on voices from the ground.

Findings are organised into four chapters covering opiate markets, amphetamine-type stimulant (ATS) markets, kratom, and cannabis, followed by a concluding chapter that discusses cross-cutting themes and policy recommendations.

There are important limitations to note. Much official data – particularly from state agencies – relies heavily on drug seizure statistics, which reflect law enforcement priorities more than actual consumption or trade volumes. Moreover, such seizures can shift production and distribution to new areas or alter drug availability, pricing, and use patterns.

The Covid-19 pandemic also posed serious challenges, limiting access to research sites and adding mental, economic, and social strain on the communities involved. While this report categorises substances into separate chapters, in practice polydrug use is common, and trade networks overlap significantly – including with other licit and illicit economies beyond the scope of this study.

In addition, the research was hampered by return of military rule in Myanmar after the 2021 coup, which was met with nationwide resistance. Initially these were largescale but peaceful demonstrations, but these were met with brute violence by the newly-established military State Administration Council (SAC). Since then, many civilians have formed People's Defense Forces (PDFs) to take up arms against the SAC and to bring down the military dictatorship. They joined many existing ethnic armed opposition groups, and armed conflict has now spread to many parts of the country. This made research on trends in the national drugs market challenging, and some areas were difficult to access.

Throughout the report, drug prices are given in local currencies with approximate euro equivalent at the time of interview. Quotes are kept as close as possible to their original wording, lightly edited for grammar and clarity. Textboxes highlight case studies and specific themes that complement the broader analysis.



Collecting raw opium in Kachin State, Myanmar (SKT)

2. The Resilience of the Opiate Market in the Golden Triangle

This chapter analyses how the opiate economy in what is popularly known as the "Golden Triangle" – roughly the border regions of northern Myanmar, Thailand and Laos – has persisted and adapted despite decades of prohibition. It first reviews recent global developments in opiates and opioids, then examines cultivation, trade and use in Myanmar and neighbouring countries, before outlining the social and policy implications that link local livelihoods to regional and global markets.

In spite of ever-increasing anti-narcotics operations conducted by governments and law enforcement agencies around the world, the opiates and opioid[1] drugs markets have continued to evade control, and to evolve, expand and diversify. New substances have partly displaced others, as illustrated by the fentanyl crisis in North America, while levels and areas of production have fluctuated and trafficking routes have shifted to adapt to new economic and political realities.

The drugs market in Southeast Asia has seen a shift from being dominated by an opiate economy to one in which amphetamine-type stimulants are the main drugs, both in terms of production and use. Poppy cultivation in the Golden Triangle saw a significant decline from the peak levels in the 1990s when it was the largest opium producing area in the world. At the same time, criminal networks in the region shifted to mass production of ATS – initially mainly methamphetamines – which quickly became the new drugs of choice, especially among youth, and a highly profitable enterprise. The situation was further exacerbated with the introduction of large-scale production of crystal methamphetamines in Myanmar's Shan State, known as "ice" for its snow flake-like appearance, mainly for export.[2]

However, the opiate market in the Golden Triangle has shown strong resilience. In 2024 and 2025 Myanmar emerged – once again – as the largest poppy cultivating and opium producing country in the world,

following a new opium ban by the Taliban in Afghanistan. After a period of decline, the opiate market has readjusted to renewed demand and investment. Opiate use has not disappeared from the region – heroin prices have fallen, particularly in Myanmar, and it is more readily available than at any point in the last decade, filling a continued demand in the country. And although opiate use in China has been in decline, China remains a large market for heroin originating from Myanmar.

Global opium cultivation and production trends

Global opium cultivation and production have steadily increased over the last two decades. This trend began after the adoption of a Political Declaration to counter the world drug problem at the 1998 UN General Assembly Special Session on Drugs (UNGASS).[3] This 1998 Political Declaration committed Members States to "eliminating or significantly reducing the illicit cultivation of the coca bush, the cannabis plant and the opium poppy by the year 2008" and to "achieving significant and measurable results in the field of demand reduction".[4] The direction of this declaration therefore was towards eradication of crops, law enforcement and demand reduction, rather than a focus on development, health and providing services, and adherence to human rights.

The main data collection on global drug production is carried out by the UNODC. According to its 2024 World Drug Report, global opium production rose from about 4,000 metric tons in 1998 to some 8,000 metric tons in 2021 and 7,800 metric tons in 2022. During this period, opium production remained between these levels with two exceptions, both in Afghanistan: the 2001 Taliban opium ban (1,600 metric tons) and the 2017 bumper harvest (10,000 metric tons). During the same period, global opium cultivation fluctuated between 150,000 to 300,000 hectares, with the same two exceptions from Afghanistan.[5] Since the



Poppy fields in Hsanin region in southern Shan State (TNI)

Opium cultivation and use in Kachin State and Sagaing Region

Communities in Kachin State and Sagaing Region in northern Myanmar have a long history of opium cultivation. The main cultivation areas are in the Sadung area in eastern Kachin State along the China border; in Sumprabum and Putao Townships in northern Kachin State; in Danai Township in western Kachin State; and among Naga communities in the Sagaing Region.

Opium is cultivated as a cash crop as well as for traditional and medicinal use, common among Kachin and Naga communities. Part of the opium cultivated in these areas, especially in Danai Township, is relatively wet, and therefore harvested with a piece of cloth. This kind of opium is mainly used for smoking, locally known as "Khatpone". The opium is mixed with dry leaves and smoked with a bamboo pipe. This opium is not suitable to produce heroin. Most of the opium produced in Kachin State is consumed locally or in neighbouring China and India, where it is smoked rather than refined. There is also no known heroin production in Kachin State; most of the heroin available in the territory is produced in laboratories in neighbouring Shan State.

In addition, the Sadung area in eastern Kachin State has seen increasing investment in poppy cultivation from businessmen from neighbouring China, who – unlike local farmers - hire land and labourers and are able to cultivate larger plots, use irrigation, and grow on a commercial scale.

A 40-year-old Kachin man from Sumpyiyang village, located between Sumprabum and Putao in northern Kachin State, shares his experiences with opium cultivation in his community:

> "The overall area of opium fields would be around 160-200 acres annually with an average of one acre per household. They grow opium as a means of livelihood to feed themselves. Normally an acre of opium field produces around 3 to 4 viss of raw opium paste known as clothed opium, mostly from red flowered poppies...
>
> The raw opium paste weighing the same as one silver coin [old British silver coin, locally known as 'Da Kyat Thar', about 12 grammes] sells for a retail price of 15,000 kyats [9 euro] during December, January and February when the opium stock of previous year is drying out. One viss of raw opium sells for about 18-20 lakhs of Kyat [around 1100-1220 euro]. During March to November, the price gradually falls to 5,000-10,000 kyats per Da Kyat Thar, and one viss of raw opium paste only costs around 7-14 lakhs of Kyat. The earliest cultivation starts in October and harvesting runs from early March to the end.
>
> Opium yield is not much different from the past, and opium brokers are sneaking in and out of the village to purchase opium and sell most of it in Putao. Villagers mainly use opium for smoking. Most farmers sell about one viss to brokers and keep the rest to fund their children's education, often at boarding school in Putao and Myitkyina. Yet income from opium rarely covers all yearly school expenses.
>
> There is no development project in our area and it is very difficult to reach NGOs. Villagers are expecting an opium substitution programme or alternative livelihood options The community has run out of possibilities to generate income. They are also requesting training or workshops specifically organised for opium farmers."[6]

A Kachin woman from a Naga village in Danai Township, in western Kachin State, explains some of the challenges opium farmers face:

> "Most local farmers grow opium for small-scale subsistence, and it is also intended

for use in their traditional ceremonies. For example, when you harvest 3 viss [4.8 kg] of raw opium, the income from 2 viss usually covers investment and personal use. The earnings of the remaining 1 viss are exchanged for household items and food before farmers return to the fields. People feel quite trapped, as there is no viable market for other crops. There is no other alternative cash crop besides opium and rice."[7]

The farm gate prices for raw opium fluctuate during the year. According to a Naga man from Nanyun town, based in the Naga Self-Administered Zone in Sagaing Region:

"About 60% of the opium harvested in Nanyun is consumed locally and the remaining 40% is traded to outside buyers. People here grow opium mostly in areas hidden from the Ledo road. The price of one hkan [0.16 kg] of opium during the beginning of harvest in early March used to drop to 40,000 kyats [24 euro]. One hkan is equivalent to 14 silver coins and 140 silver coins make one viss of opium. The opium price per viss from March to November is around 400,000 kyats. One hkan of opium is sold for 100,000 kyats [61 euro] when the demand is at its peak. A viss of opium sells for 1,000,000 kyats in December-January and sometimes exceeds 1,200,000 kyats [730 euro] in February. Buyers of opium produced in our areas are mainly coming from Hpakant."[8]

The Naga Self-Administered Zone in the Sagaing Region borders India. A Naga woman from Nawng Yan Inn area explains:

"Pangsau Town is located 230 miles [314 km] away from Myitkyina on the Ledo Road and is not far from the border with India. It has around 100 households and residents are mostly Naga and Shan. There are few Kachin and Lisu as well. The main livelihood of the village is opium farming and this occupies around 200 acres in total. This is only an estimate, as fields are widespread throughout the area. The majority of the raw opium is consumed locally and only a small amount is trafficked to India beyond the Patkai mountain ranges."[9]

new 2022 Taliban opium ban global opium production and cultivation decreased, but as argued below the sustainability of the ban is questionable. It is likely the market will readjust itself, and poppy cultivation may bounce back in Afghanistan and/or shift to other areas (see also the section "Opium cultivation in Afghanistan" and the textbox "The Impact of the Taliban Opium Ban" below).

These trends show that more than two decades of repressive drugs policies and prohibition have not eliminated or significantly reduced illicit cultivation of opium. Instead, these policies have inflicted hardship on marginalised rural communities depending on opium cultivation for their livelihood and survival, criminalising rather than addressing the underlying causes of cultivation. Rather than tackling key structural problems – poverty, lack of access to health and education, lack of access to land, credit and markets – authorities have focused on destroying their main livelihood solution for these communities: the cultivation of opium poppy as a cash crop. While there is also traditional and medicinal use of opium among some communities, including the Kachin, Naga and Lahu[10], still the majority of poppy farmers grow it as a cash crop. According to a statement of the Myanmar Opium Farmers' Forum (MOFF):

"We want to make clear to the world why we grow opium. We are subsistence farmers living in isolated mountainous areas, and cultivate poppy as a cash crop in order to buy

food to feed our families and to buy access to education and health care for our children. So the main reason is poverty. Some people in the city may think we earn a lot of money, but we are still poor. "Rich people don't grow opium," said one farmer, "only poor people grow it!" We do not want to be seen as criminals. We are not planting opium to go against the government or against the world. We are just planting it for our survival."[11]

Opium farmers are not only poor, but also face many insecurities, as income from opium cultivation is often unstable and relatively low (though higher than income from legal crops, especially considering various challenges related to access to markets). As with other crops, farm gate prices fluctuate between years and seasons, and yields vary among others due to weather conditions (see Text Box below: "Opium cultivation and use in Kachin State and Sagaing Region"). In addition, many poppy growing regions in Myanmar are in conflict zones, which have further expanded since the 2021 coup when armed resistance against the military dictatorship spread rapidly across the country.



Incising opium pod in Kachin State (SKT)

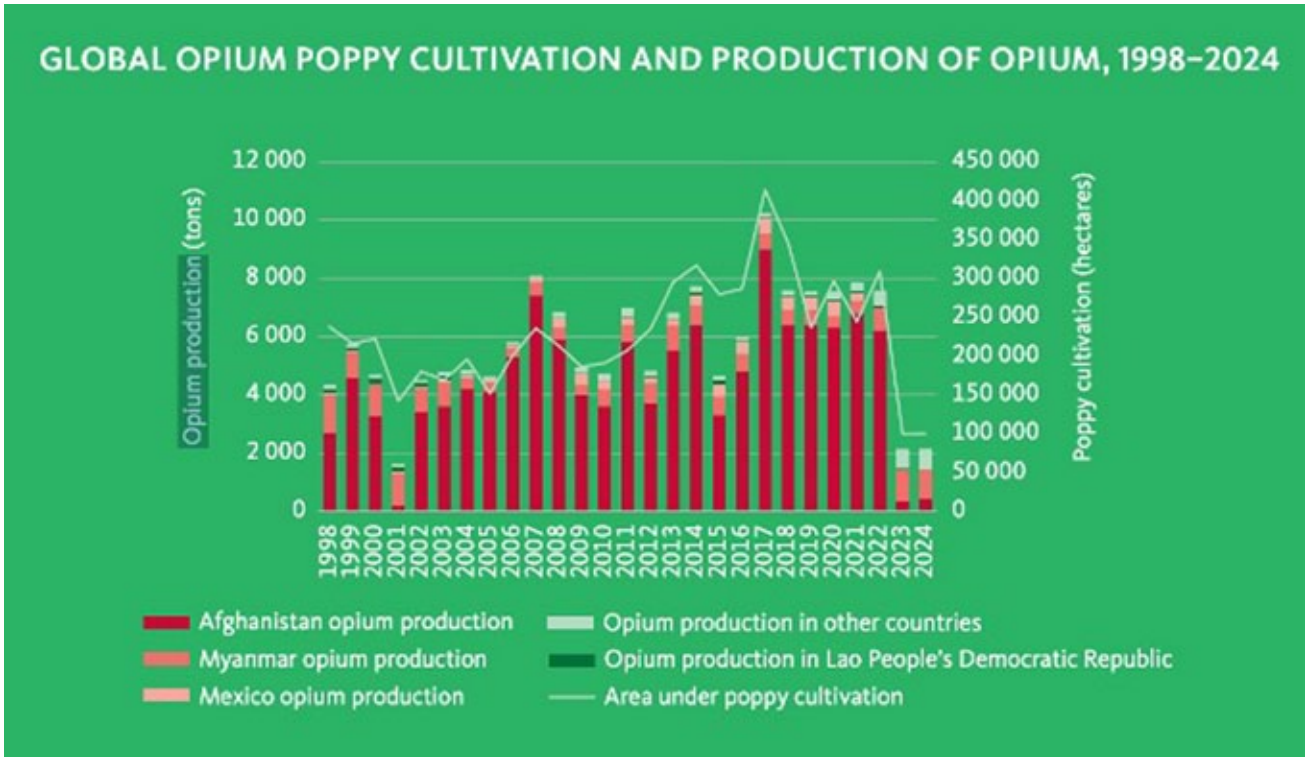
Estimating opium cultivation: data sources and limitations

The main source used by the international community to estimate opium cultivation levels are annual studies carried out by the UNODC, based on satellite data combined with field surveys. Cultivation levels and decisions on what land to use for poppy cultivation can provide an indication of the socio-economic conditions of poppy-growing communities. However, every area where opium is cultivated and produced has its own characteristics – climate, planting and harvesting seasons, soil and water conditions, extraction methods and labour requirements – all of which influence the yield of each opium cultivation season at any given time and location. UNODC estimates opium production based on yield surveys in selected areas, which are then extrapolated across hectares used for opium cultivation. While opium cultivation levels can provide information about the potential amount of raw opium and its derivative heroin likely to reach global markets, the data remain highly debatable.[12]

Global opium cultivation has remained highly concentrated, with just a few countries accounting for the bulk of global opium production. From 2015 to 2020, Afghanistan alone represented an estimated 83% of global opium production, while Myanmar and Mexico were estimated to have contributed 7% and 6% respectively.[13] The total area under poppy cultivation in Mexico remained relatively stable during that time, reaching an estimated opium production of 440 metric tons in 2018-2019. This places Mexico roughly on par with levels of cultivation and production observed in Myanmar during the same time.[14]

However, these data should be treated with caution, and comparisons are difficult. As argued earlier, annual opium surveys are useful indicators of local and regional trends

Figure 1: Global opium cultivation 1998-2024[15]



Source: UNODC World Drug Report 2025

in opium cultivation and production, but they have their limitations. The UNODC surveys use broad ranges for both opium cultivation and production – an indication that there are substantial margins for error.[16] In addition, some key opium producing countries, such as India, do not have surveys at all. Using other UNODC figures and data from the Indian government during the period 2011-2013, it could be argued that India was the world's third-largest cultivator at that time, and potentially also the third-largest producer of illicit opium.[17] Data for Mexico are not available for 2021 and 2022. The Laos government officially declared the country drug-free in 2015, and since then no survey has taken place until 2023, when UNODC found some 5,000 ha of poppy cultivation, about the same levels as in 2015.[18] This left the UNODC global opium surveys for 2021 and 2022 only with data for Afghanistan and Myanmar, and non-specified 'other countries'.[19]

A closer look at the situation in these countries reveals diverging trajectories. Opium cultivation and production rose significantly over the past decades, albeit with important year-on-year fluctuations. Afghanistan overtook Myanmar, Laos and Thailand – known as the Golden Triangle – as the world's largest opium producer in the early 1990s, and has kept that position, with the exception of the 2001 and 2022-2024 Taliban opium bans (see below). Afghanistan also became the world's largest opium cultivating region in 2003. The main reason for this difference in timing is that opium yields in Southeast Asia are much lower than in Afghanistan.[20]

Many challenges and gaps remain in understanding the drivers and consequences of opium poppy cultivation in different countries. They are complex and dynamic and subject to wide variations over time and across countries. Rather than relying solely on UNODC opium surveys, greater collaboration is needed with local communities involved in opium poppy cultivation to survey and analyse data. This collaboration should extend to the design, implementation, monitoring and evaluation of programmes addressing the root causes of poppy cultivation. This has been greatly hampered by the continuous criminalisation and stigmatisation of opium farmers.

On the drug use side, significant progress has been made in international discussions and policy implementation. In various countries around the world drug use has been decriminalised, and drug users – especially those living with HIV – have been involved in policy making. For instance, they have had seats on the Country Coordination Mechanism of the Global Fund to fight AIDS, Tuberculosis and Malaria in several countries in Asia, including Myanmar.[21] However, for impoverished communities involved in poppy cultivation, no comparable opportunities for participation exist.

Opium taxation practices in Myanmar

Since opium farming is illegal, farmers have to pay "taxes" or bribes to local authorities. In one of the meetings of the Myanmar Opium Farmers' Forum (MOFF), farmers reported they had to pay money to everyone "who wears a uniform and carries a gun". One female Pa-O opium farmer explained:

> "In our village, every household that grows opium has to give a certain amount of money to the village headman. The village headman then negotiates with local authorities and armed organisations to avoid eradication."[22]

Some ethnic armed organisations (EAOs) opposing the SAC and local militias officially under Myanmar Army control who operate in poppy growing regions have their own taxation systems. Some collect a certain amount of money for the whole village, based on the total cultivation area, with the village head responsible for collecting contributions from individual households. In Kayan-inhabited areas in Pekhon and Demoso Townships contribution of opium tax is collected based on the number of working forces in each individual household, locally known as "hoe tax". According to Kayan tradition, it is regarded that one hoe represents one workable adult in the household. If one family owns five hoes, it means that the family have five working adults.

In the case of United Wa State Party (UWSP), before its opium ban in 2005, the organisation collected roughly 10% of the opium harvest as tax. Tax officers would travel to opium farming villages shortly after the harvest season, usually in January, to collect opium from individual households and submit it to upwards into the administrative hierarchy; from village to village tract and further to township and to district, and then finally to the headquarters in Pang Kham. Opium tax used to contribute up to 30% of the UWSP annual revenue and was a crucial source of hard currency, enabling the UWSP to strengthen its army with modern weaponry from the black market through transnational criminal networks.

Some EAOs also seek to control the opium market by enforcing rules that require farmers to sell only to traders connected to them, often at prices below market value. Outside traders are not allowed to buy opium in their controlled area, and farmers who break the rule face severe punishment. As shared by one Shan male opium farmer from the Panglong area of southern Shan State under the control of the Shan State Progressive Party (SSPP):

> "We are only allowed to sell our opium to traders who come to the village with them. The price those traders offer is much lower – about 20 to 30 per cent lower than in other areas. Although we know we could get a much higher price elsewhere, no one dares to take the risk. They have guns and can do anything to us – fine us, confiscate our property, put us in jail, or even kill us."[23]

Opium cultivation in Afghanistan

In 2021, annual production in Afghanistan exceeded 6000 metric tons for the fifth consecutive year, remaining at historically high levels.[24] This expansion occurred even though the U.S. Government reportedly spent an estimated $8.6 billion between 2002 and 2017 in an effort to suppress Afghanistan's drug trade.[25] These resources funded eradication campaigns, alternative-crop programmes, law enforcement operations, and airstrikes on suspected heroin laboratories. According to retired U.S. Army General Joseph Votel, former Commander of U.S. Central Command (2016 – 2019), those efforts "didn't really have much success."[26]

Moreover, the severe economic and political crises triggered first by Covid-19, and then by the Taliban's return to power in 2021, further increased food prices, pushing more households toward poppy cultivation as a survival strategy.

Meanwhile, a new ban on opium and other drug crops was reinstated in April 2022 by the Taliban, responding to international pressure for stronger drug control.[27] At the time, Afghanistan remained the world's largest supplier of opium and an expanding producer of methamphetamine.[28] The initial impact of the ban remains limited. According to researcher David Mansfield, "[t]he second [annual] crop in south-western Afghanistan is typically a small crop… so its destruction… will not have had a significant impact."[29] The UNODC World Drug Report 2023 likewise reported that Afghanistan's 2022 yield still represented 80 percent of global opium production.[30]

The full impact of the ban emerged a year later. The UNODC Afghanistan opium survey 2023 estimated that opium cultivation dropped from around 230,000 hectares in 2022 to 10,800 hectares in 2023. In 2024, UNODC reported that while cultivation rose slightly – by nearly 20% to 12,800 ha - it remained far below pre-ban levels.[31]

In the same period, UNODC estimated that opium production in Afghanistan fell by 95 per cent, from some 6,200 tons in 2022 to 333 tons in 2023. According to the agency, this decline caused a 92% drop in farmers' income – from an estimated US$1,360 million in 2022 to US$110 million in 2023 – leading to what it described as "dire economic and humanitarian consequences for the impoverished country".[32] An international economist who has followed the Afghan drug market for decades similarly warned: "The ban is not a counter-narcotics victory and will have negative economic and humanitarian consequences, potentially leading to a refugee crisis".[33]



Farmer harvesting opium in Nanghar Province in Afghanistan (TNI)

However, some sources suggest the decline was less pronounced, and that poppy cultivation persisted or even rose in certain areas. As one report observed:

> "[There] is now no dispute that poppy cultivation has decreased sharply and is a small fraction of the 2022 harvest… However, the two publicly available estimates of the remaining opium harvest in 2023 differ greatly. UNODC's recently published Afghanistan Opium Survey

> estimates that overall national poppy cultivation declined by 95 percent, whereas satellite imagery analysis by Alcis indicates an 86 percent reduction in cultivation… This roughly 10-percentage-point gap between estimated changes in poppy cultivation would not have been a big deal if the absolute magnitude of the change were not so large."[34]

Apart from uncertainty about the extent of the decline, the sustainability of the ban remains doubtful. As seen earlier, poppy cultivation is deeply tied to livelihoods in impoverished rural areas. The Taliban's earlier 2001 opium ban collapsed after one year because it failed to provide alternative incomes for farming communities that relied on opium to purchase food, medicine and education. The ban also triggered a sharp rebound in cultivation the following year, as many indebted farmers – having taken advance credit on expected harvests – grew even more poppy to repay debts and survive.[35]

Even if the Taliban manages to maintain the current ban, historical patterns suggest displacement rather than eradication – the so-called balloon effect. Given ongoing instability in Myanmar and its upward trend in poppy cultivation, the Afghan ban may further stimulate a resurgence in the Golden Triangle, where heroin from Myanmar could again reach European markets. Rising heroin prices due to global shortages could reinforce this dynamic. However, as noted earlier, during the 2002 Taliban ban stockpiled opium and heroin in the supply chain helped cushion global markets, delaying any major shift.[36]

The Taliban opium ban has also further fueled a shift toward synthetic drug production, particularly methamphetamine. According to a 2023 UNODC report on the issue, methamphetamine seizures in Afghanistan and neighbouring countries rose substantially between 2019 and 2021, with most believed to originate domestically. Some of these seizures have occurred in Europe, the Middle East and parts of Africa.[37] Production is partly enabled by the abundance of the ephedra plant, a natural source of ephedrine – a key precursor for methamphetamine.[38] Ephedrine is also obtainable from pharmaceutical products on licit markets. Amphetamine production is a highly profitable business. A similar pattern was observed in Myanmar, where heroin producers shifted to manufacturing ATS after opium bans imposed by armed groups in major poppy-growing areas. The same trend may now again develop in Afghanistan. In 2025, UNODC reported that "methamphetamine seizures have become more frequent and average weights have remained increased".[39]

Another consequence of the Taliban ban is the sharp decline in heroin production and, consequently, a reduced global supply – coinciding with the rise of potent synthetic opioids. In the United States, the spread of fentanyl – an opioid about 50 times more potent than heroin – has led to a surge in overdoses.[40]

More recently, an academic research paper on the use of synthetic opioids in the United Kingdom warned that:

> "The UK is in the midst of a drug-related crisis. The Taliban recently prohibited opium cultivation, leading to a dramatic reduction in production. The resultant gap in the market could lead to nitazenes becoming increasingly prominent across Europe."[41]

Nitazenes are synthetic opioids developed in the 1950s but never approved for medicinal use. Some variants are hundreds of times more potent than heroin and can cause fatal respiratory depression.[42] A few months later, Alexis Goosdeel, Director of the European Union Drugs Agency (EUDA), issued a strong warning for the European Union to prepare for a future heroin shortage:

> "The question is what will happen next? The risk is that those who are using heroin will switch to drugs that are cheaper, easily produced and much more dangerous than heroin. Some of them can be 700 times more potent than morphine."[43]

In Southeast Asia, as seen earlier, opium bans and the subsequent reduction of heroin

Impact of the Taliban Opium Ban

The Taliban ban and subsequent forced eradication efforts in the years thereafter were the major causes of accumulated debt, which became the main driving force behind the rapid expansion of poppy cultivation. A report analysing the determining factors behind farmers' decisions to grow opium poppy illustrates this perverse cycle with dramatic examples.[44]

A male barber-farmer in Khogiani, for example, took an advance payment of US$400 on 4 kilogrammes of opium from an opium trader in 2000 to pay for treatment for his sick father. Due to the Taliban ban, he was unable to harvest and therefore could not repay his debt. When interviewed early 2004, he said the trader now demanded the equivalent of twenty kilogrammes of opium – about US$7,200 – as repayment for the original loan and interest accrued.

After mediation, it was decided that the barber would give his daughter to the trader to settle US$3,200 of the debt, and mortgage two jeribs (0.4 hectare) of his land against the remaining US$4,000. The account is striking not only because of the economic loss involved, but because the debt had become severe enough to put both land and family at stake. The barber hoped he could repay the rest of the loan and regain his land. No similar possibility of return is mentioned for his daughter. The only way to do so was to cultivate more opium this season.[45] Similar accounts of debt, loss and family hardship have been documented across Afghanistan.[46] These were the main reasons why the Taliban could not sustain its opium ban, as it was unable to provide alternatives for farmers.

production also produced serious health consequences. In the 2000s, declining opium cultivation led to a heroin shortage, reduced quality and higher prices, pushing many heroin users to switch from smoking to injecting – a more cost-effective but risky practice. This shift coincided with the region's HIV/AIDS epidemic, in which injecting heroin users became a key high-risk group (see section 'The heroin epidemic in Myanmar' below). While such bans were heralded as major successes in drug control, they carried unintended and severe public-health costs.[47]

Opium cultivation in Southeast Asia

Opium cultivation in Southeast Asia mainly takes place in Myanmar, and to a lesser extent in northern Laos and northern Thailand. In contrast to Afghanistan, estimated opium cultivation in Myanmar followed a downward trend between 2013 and 2020, shrinking by almost 50%, as is shown in table 1 below.[48] However, since then, both farm-gate prices and cultivation levels have risen again. Farmers told TNI that, unlike in previous years, traders now return to their villages to buy opium and offer better prices. According to UNODC, poppy cultivation in Myanmar increased by over 30% to around 40,000 hectares in 2022, and an additional 6% further to 47,000 hectares in 2023, with an estimated output of 1,080 tons – the highest level since 2001. By 2025, cultivation further increased by 17% to an estimated 53,000 hectares.[49] Following the Taliban's 2022 opium ban in Afghanistan, Myanmar once again became the world's largest producer of illicit opium.

However, opium cultivation and production in Afghanistan over the last three decades has remained much larger than in Myanmar. As mentioned above, in 2022 poppy cultivation in Afghanistan covered some 230,000 hectares, compared to about 40,000 hectares in Myanmar (about 17%). In the same year, opium production in Afghanistan amounted to an estimated 6,200 tons, compared to just under 800 tons in Myanmar (about 13%). One major difference lies in opium yield: in

Table 1: Opium cultivation and production in Afghanistan and Myanmar 2017-2025

year	Opium cultivation Afghanistan (ha)	Opium cultivation Myanmar (ha)	Opium production Afghanistan (ton)	Opium production Myanmar (ton)
2017	328,000	41,000	9,000	550
2018	263,000	37,300	6,400	520
2019	163,000	33,100	6,400	508
2020	224,000	29,500	6,300	405
2021	177,000	30,200	6,800	423
2022	230,000	40,000	6,200	795
2023	11,000	47,000	333	1,080
2024	12,800	45,200	433	995
2025	10,200	53,100	296	1,010

Source: UNODC Afghanistan and Southeast Asia annual opium surveys 2017-2025

Afghanistan, the average yield used by UNODC over the past 6 years is 31 kg per ha,[50] while in Myanmar the agency estimated 19.8 kg in 2022 and 22.9 kg in 2023.[51]

Opium production in Southeast Asia is primarily characterised by fluctuating cultivation levels and prices, shaped by factors ranging from global drug demand patterns to local socio-economic conditions to weather patterns and policy responses. These shifts involve diverse actors with varying resources, needs and influence over the drug trade.

Despite these variations, the underlying drivers of opium cultivation across Southeast Asia – particularly in Myanmar – remain largely unchanged.[52] In the midst of poverty, conflict and extractive dispossession, small-scale farmers with little access to land, market or socioeconomic support continue to rely on opium as a vital livelihood.

According to UNODC, Shan State accounts for over 80% of Myanmar's total poppy cultivation.[53] Historically, opium cultivation in the Golden Triangle rose steadily since World War II, peaking in the 1980s, when the region became the world's largest producer and a major supplier to European and American heroin markets. A first period of decline occurred between 1997 and 2006, as ceasefires between the Myanmar military government and ethnic armed groups located in the main poppy growing areas in Shan State were followed by opium bans imposed by these groups. These were largely made under pressure from China, which faced a rise in heroin injection and HIV/AIDS transmission, particularly in Yunnan Province. Critics argue that these bans were implemented before communities had viable alternatives, pushing many into deep poverty. Families long dependent on opium for food, clothing and medicines struggled to survive, and food insecurity worsened.[54]

The Myanmar military government, then called the State Peace and Development Council (SPDC), was both unwilling and unable to provide assistance. UN agencies and international NGOs, mainly Western-funded, implemented limited alternative development projects, but these were insufficient to replace the opium economy. The World Food Programme (WFP) provided short term emergency support, but this only addressed immediate food needs. The Kokang and Wa authorities were unable to support ex-poppy farmers, and mostly relied on assistance from China, which adopted a different approach.

As discussed earlier, most opium and heroin consumed in China originates from northern Myanmar. In response, the Chinese government launched an 'Opium Replacement Programme', promoting Chinese company investment in crops such as rubber, tea and

banana through subsidies, tax waivers and import quotas. While framed as development assistance, these initiatives primarily benefited Chinese business interests and local authorities, further marginalising ex-poppy farmers. A TNI study highlighted several unintended outcomes: (1) renewed increases in opium cultivation in Myanmar after 2006; (2) a parallel surge in Chinese agricultural investment, especially in rubber; (3) widespread land dispossession and loss of livelihoods in northern border areas.[55] Together, these developments show how regional drug-control and economic policies can reinforce rather than reduce marginalisation in Myanmar's borderlands.

Resurgence and resilience of opium cultivation in Myanmar

The resilience of the Southeast Asian drug market became evident when opium cultivation in Myanmar rebounced between 2006 and 2014. As domestic opium supplies declined, reduced availability of raw opium and heroin pushed up prices - stimulating renewed investment and expanding cultivation. Poppy fields gradually shifted southwards, particularly across Shan State, where existing cultivation intensified and was introduced in new areas.[56]

Poppy cultivation declined again after 2014, largely due to a continued shift of investment from the opiate economy to the more lucrative ATS business, particularly crystal methamphetamines. This new market attracted both established and new actors.[57] Farmers reported reduced demand for raw opium, falling farm-gate prices, and fewer buyers visiting villages. According to a 2019 statement from the Myanmar Opium Farmers' Forum:

> "[The] traders are more interested in the more profitable ATS trade. There is a growing local demand, and traders can expand production and sales. ATS now has a bigger market than opium, is easier to produce, transport and use, and yields higher profit margins. The rich now invest in land and real estate rather than opium. Only a few buyers still come to our village."[58]

This downward trend reversed again starting with the poppy planting season in late



Raw opium harvested in Kachin State, Myanmar (SKT)

Ex-poppy farmers speak - the impact of the Kokang and Wa opium bans[56]

The Myanmar National Democratic Alliance Army (MNDAA – Kokang region) and United Wa State Party (UWSP – Wa region) implemented opium bans in 2002 and 2005 respectively, following international pressure – especially from neighbouring China. In return, these groups hoped to gain international political recognition and aid for their impoverished and war-torn regions.

The bans ended over a century of poppy cultivation in the Kokang and Wa regions, once the main opium producing areas in the Golden Triangle, but had severe consequences for local communities. Many ex-poppy farmers were forced to reduce food intake, seek daily wage labour – often on rubber or tea plantations under China's Opium Replacement Programme – and rely on forest products for food and sale.

As a 70-year-old Wa man from Naung Khit Township explained:

> "We have less money after the opium ban because we do not have any source of income. We cannot buy meat or clothes, and big families struggle to feed their children. People try to find work on plantations, but unlike before the opium ban jobs are scarce now. We must also perform unpaid work for the authorities – building roads, clearing land."

An important coping mechanism for ex-poppy farmers is collecting non-timber forest products (NTFPs), including roots and tree bark, which are sold to Chinese traders. While this offers small income, it has harmed local biodiversity. A 45-year-old Wa woman described:

> "Our only income is from collecting roots from the forest. We dry and sell 2 kg for 5 Yuan [0.50 euro] - it takes us 4 days to gather. We rarely find paid work; when we do, we earn 20 Yuan a day. Our main food is bamboo shoot curry; meat is rare. Before the ban, we earned enough from poppy; now we rely on roots to survive."

A Wa man from Mong Mao District also described the loss of income sources:

> "After the ban, money is very difficult to find. Before, I could buy rice, salt, chilies and oil. Now I try to work on rubber plantations, but work is scarce. Last year, I received rice aid for developing land."

Following the ban, communities were desperate, with few means to adapt. A 32-year-old Wa man recalled:

> "In the first year after the ban, we were really in trouble and didn't know what to do. We helped each other to survive. Now we earn some money from rubber work and have developed some land. We received UN rice support."

The ban also affected children's nutrition and education. A 47-year-old Kokang woman explained:

> "I used to grow opium on other people's land and shared half the yield with the owner. Now I grow upland rice and corn – it feeds us for four months, but food soon runs out. I look for daily labour. I earn 7 to 15 Yuan [0.70–1.50 euro] a day, working in

sugar cane fields. I use the money to buy rice and clothes. My children, aged 12 and 15, also have to work. Before, we ate better, but now we depend on the WPF for rice."

A 32-year-old Wa man from Man Man Sein Township described the cycle of debt:

"In the past when we took a loan, we would pay it back in opium when the harvest came. If we borrowed money, and the market price for a viss was a thousand Yuan [105 euro], we would have to pay back about fifteen or sixteen hundred Yuan. It depends on your relations, if you can borrow in towns from friends who live there. We have no direct connection with Chinese traders, but we deal with the Wa or Shan brokers. Now we miss the trust to get a loan. We have to survive by getting daily wages. Taking loans is like a cycle. We were always in debt, and we got deeper in debt. Some people here are still in debt from the time we grew opium, they could still not pay back, even after four or five years."

Communities in an opium economy used to have easier access to credit, as traders advanced payments for future harvests, ensuring low-cost raw opium during the season. Poor subsistence farmers often accepted advances at low prices because they could not afford to wait for harvest. When the market vanished after the bans, traders lost interest in financing less profitable crops, and credit dried up. This pattern, seen in both Myanmar and Afghanistan, highlights how poppy bans erode local credit systems.

A 53-year-old Kokang man reflected:

"Before the ban, my main crop was opium. In 2001, I harvested 1 viss, which I sold for 5,000 Yuan [520 euro]. Growing poppy meant food security, but we couldn't save. We took advance loans but couldn't repay. Now we are debt-free, but we eat poorly. Paddy doesn't grow well at this altitude. We rely on corn and newly planted walnuts, but there is no income yet."

While communities in the Wa region suffered greatly from the opium ban, the epicentre of poppy cultivation simply shifted to southern Shan State and, in the long run, overall cultivation levels did not significantly decline.

2020. Farmers from Shan State reported not knowing the reason why farm-gate opium prices had risen but noticed that more traders were coming to their villages again competing to buy their harvests. Prices reached 800,000-850,000 (about 350-375 euro) MMK per viss in 2023, up from 600,000 MMK in 2022 – an increase of 30-40%. Rising demand for Myanmar opium was a key factor for the resurgence of cultivation.

Some observers linked this rise to the economic collapse and instability following the military coup of 1 February 2021.[60] A nationwide protest movement emerged and was violently suppressed, triggering widespread conflict. By late 2024, more than four million people were internally displaced, 30,000 killed in conflict zones, 20,000 political prisoners detained and over 5,000 civilians killed by the security services.[61]

However, the 2021 opium harvest came from crops planted months before the coup, in September-October 2020. The surge in cultivation thus preceded the military takeover. Nevertheless, both the coup and its aftermath deepened hardship, particularly in rural and conflict-affected regions. These communities were already struggling with the impacts of Covid-19, including border closures, restrictions on movement, loss

of market access, and return of migrant workers,[62] all of which pushed farmers towards expanding poppy fields.

The decline in prices of licit cash crops – such as maize, cheroot leaves, ginger, garlic, avocado and tea – also encouraged farmers to expand opium cultivation. At the same time, the price of essential goods skyrocketed during the pandemic, leaving opium as one of the few viable sources of income. A woman from southern Shan State explained:

> "During Covid-19 in 2020-2021, we could not leave the village without permission. It was really difficult to sell our [licit] crops, and traders cut prices knowing we needed cash. At the same time, they raised prices on goods we had to buy. Without income from opium, my family could not have survived."[63]

Another woman grower from southern Shan State shared:

> "We don't get good prices from our [licit] crops – it's gotten worse in the last two years. During Covid-19, we couldn't travel or sell our produce. Prices of goods we buy keep rising, and life is becoming more difficult."[64]

Opium cultivation trends in Myanmar

Interviews by TNI in the end of 2023 and early 2024 suggest steeper rises in poppy cultivation, as confirmed by a male opium farmer from Loilem Township in southern Shan State:

> "Many farmers from my village expanded their opium fields as prices kept rising. Some even cut down tea and avocado trees to plant poppy. Those who had stopped cultivating in 2017–2018 due to low prices resumed again. I nearly doubled my field size compared to last year. In our village,

A male poppy farmer from Kanpaiti in eastern Kachin State speaks

"I started growing poppy a decade ago, though some years I stopped. Why did I grow poppy? Simply to feed my family. No other crops grow well in the Sadung area. We grew poppy during the NDA-K period and continued under BGF rule.[65] The government issued an order banning cultivation, but offered no real support or alternatives.

I could not afford to plant large fields. I lost all my investment one year when I cultivated two acres of poppy, because heavy rain during harvest destroyed the crop. I was in serious trouble and unable to repay the loan. The weather is crucial for opium cultivation; a change in climate can mean total loss.

We used to take loans from Chinese traders whenever we needed money to plant. They had easy access to capital through government-backed credit in China, which they invested in opium cultivation in Sadung and Kanpaiti.

You don't get rich by growing opium, but we continue because it keeps us alive. Large scale commercial farming needs big capital, which we don't have. We grow mainly for subsistence and survival.

The price of opium in 2020-2021 dropped sharply, and we earned little. The main reason was difficulty in selling to Chinese buyers, as demand fell. Covid-19 restrictions and China's economic slowdown reduced access to loans and credit, limiting their involvement in opium cultivation. For local people, we keep growing because no other livelihoods exist here." [66]



Irrigated poppy fields in southern Shan State (TNI)

opium cultivation has increased by at least 30 percent."[67]

In addition, farmers report adopting new cultivation techniques, such as using herbicides for weed control, installing sprinkler irrigation systems where water is available to grow summer poppy (January – April),[68] and combining chicken manure with chemical fertilizers to increase yields.

The opium price continued to rise through early 2024, particularly after fighting broke out in Hsihseng and Hopong Townships in southern Shan State – major opium growing areas. The clashes involved the Myanmar Army, supported by the Pa-O National Army, against the Pa-O National Liberation Army and allied People Defence Forces, part of the "Spring Revolution" opposing the 2021 coup.[69] In early January 2024, the opium price in the area was about 800,000 MMK (342 euro) per viss. When fighting erupted, prices rose quickly. A female opium farmer from Hsihseng township explained:

> "The price had already been rising since late 2023. When the fighting began, it went up every day. Many buyers came to our village and competed to offer higher prices. I sold mine for 1.2 million Kyat [520 euro] per viss in early March 2024."[70]

During this period of armed conflict, farmers witnessed one of the enduring features of the opium economy: "opium doesn't need to find money; money will find the opium." As one male opium farmer from Hopong Township recounted:

> "When fighting broke out near our village last month [February 2024], we had to flee into the forest for our safety. I could not bring much of my properties as I was on the run with my pregnant wife and two of our kids. I put some rice, salt, canned meat and dried fish in a bamboo basket that could last for one week to feed my family. At that time, I remembered what we used to say at the meetings of the Myanmar Opium Farmers' Forum: 'Wherever you hide, if you have opium, the buyers will find you.' I carried 2 viss of freshly harvested opium – and on the fourth day, two traders came to buy it."[71]

In contrast, farmers in the Hsa Nin mountain range in northeast of Loilem Township reported lower prices. This area has become a major poppy cultivating area, with many

farmers mono-cropping and growing little else. This area was once known for tea and cheroot leaves cultivation. However, in 1998 the whole village was forced to relocate due to a "Four Cuts" campaign by the Myanmar army, to deny popular support to the Restoration Council of Shan State / Shan State Army South (RCSS/SSA South – ethnic armed opposition group). Several years later, when people were able to return, they found their village and their tea and cheroot leaf plants destroyed. Villagers say the only cash crop available for them at that time was opium. The RCSS, which had taken control of the area, allowed farmers to cultivate poppy, levying an opium tax. In the end of 2021, the RCSS was pushed out of the area by the rival Shan State Progressive Party / Shan State Army North (SSPP/SSA North).[72] The SSPP/SSA North then monopolised the opium market, and forced farmers to sell their opium to selected traders at a fixed price. A male Shan opium farmer from Hsa Nin explained:

> "Buyers only offered us 900,000 MMK per viss [390 euro] this month [February 2024]. We have no choice but to sell it to them, as we cannot bring our opium to other places for a better price. The SSPP/SSA controls all the checkpoints, and only traders connected to them can buy opium here."[73]

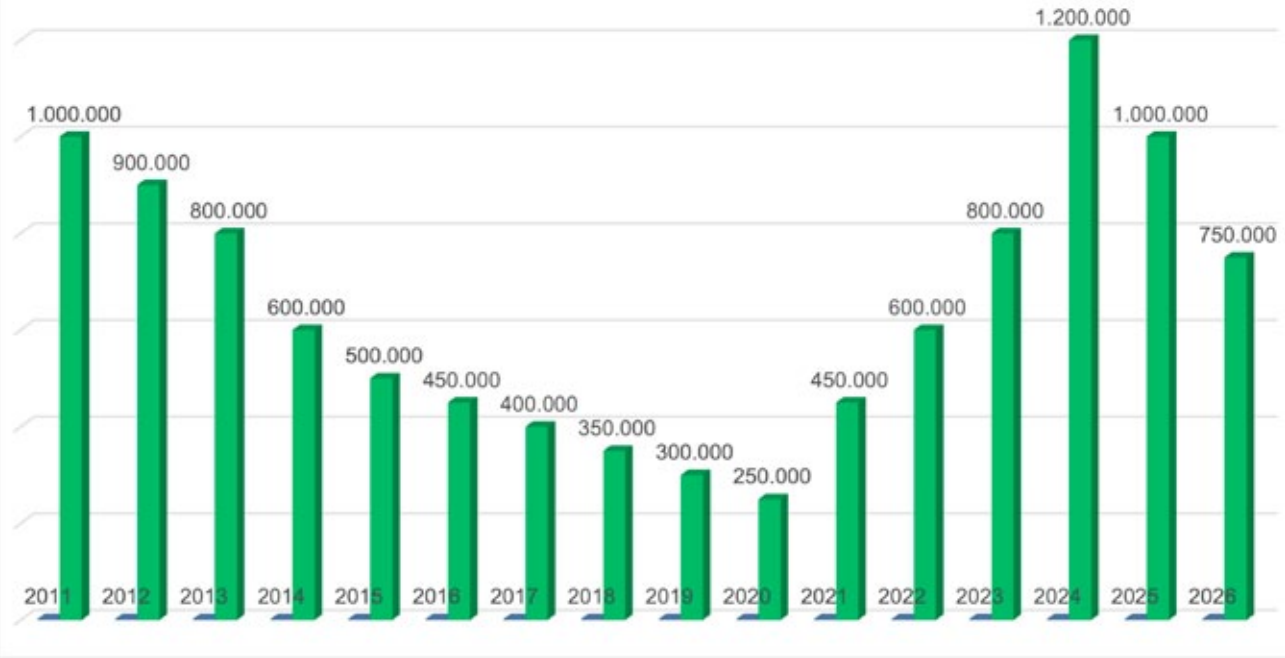
Since 2025, opium prices have dropped again, resulting in decrease in cultivation. According to a female Pa-O farmer from Hsisheng Township:

> "During 2016-2020 the opium price was very low. After 2021 the opium price was very good, until 2024. Now it is going down again. During 2021-23 the price was 1,500,000 MMK for 1 viss. During 2024-2025 it dropped rapidly, and now it is 700,000-800,000 MMK per viss. How we cope with this? We cannot reduce our food intake, we cannot skip meals. But almost all families have migrant workers, and we have village loans. This is how we cope."[74]

Other farmers point out that migration and a flash flood in 2024 also contributed to the recent decline in poppy cultivation. According to a male Pa-O farmer from Hopong Township:

> "Opium cultivation also dropped because of migration. It is difficult to secure labour to work on our fields, as many families have no workforce left to grow opium. We

Figure 2: Farmgate opium prices in Southern Shan State 2011 - 2026 (MMK per viss)



Source: Myanmar Opium Farmers Forum (MOFF)

used to grow opium, but the labour costs are too expensive, so this year I just leave the field. This year opium price is very low, so cultivation level dropped in our village. Now it is about 650,000 to 700,000 MMK per viss. During the flash flood, many slopes were damaged. Opium grows best at these slopes. Now there is only 1/3 of opium cultivation compared to last year in my village."[75]

A Shan male opium farmer from Loilem Township also provided a number of reasons for the current decline:

> "The opium cultivation level decreased because of the low price for raw opium. Then there is conflict, there are too many armed groups. Many people have migrated to Thailand, so it is very difficult to find labour. As a result, only two thirds of opium cultivation remains in my area. Now we focus more on coffee."[76]

Added a Pa-O male opium farmer from Hopong:

> "The opium price maybe dropped because one opium refinery got raided and destroyed this year. And one drug cartel got arrested, a Chinese lady who was the leader. These events have impact on the opium price."[77]

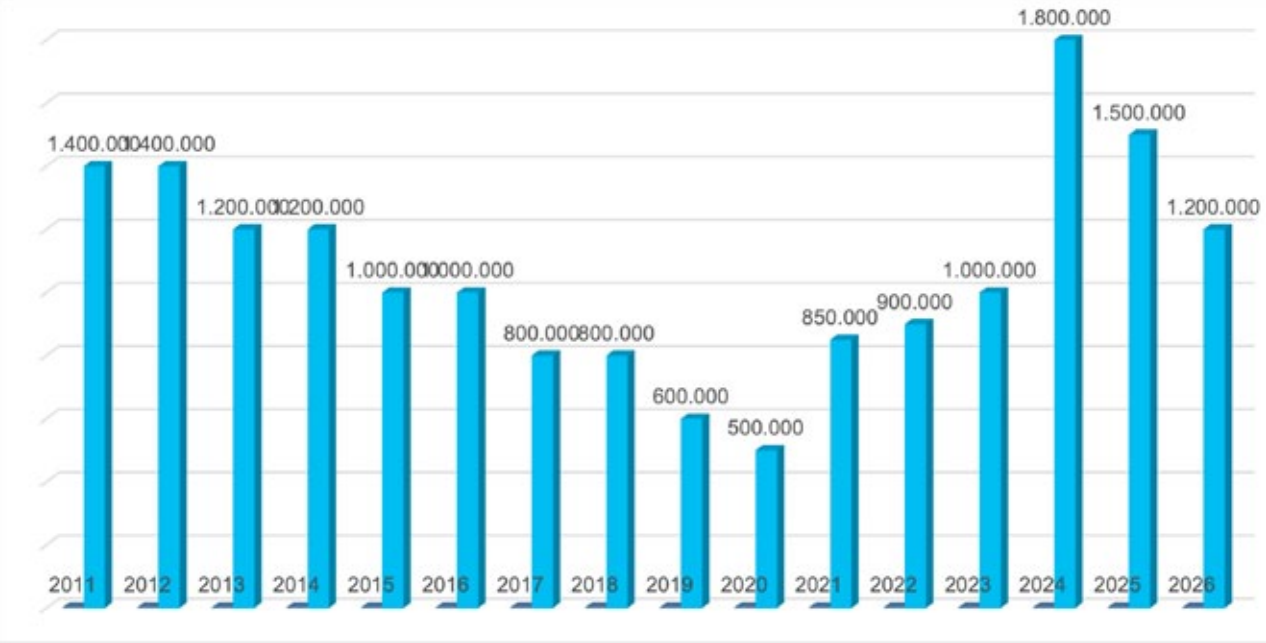
However, trends are diverse, and some farmers report an increase in cultivation. According to a female Pa-O opium farmer Hopong Township:

> "In my village only 10 households still grow opium, because we have a stable coffee market. We are connected by road. This also means that eradication teams come to our village first [because it is easier to reach]. But in some other areas opium cultivation has increased. In Kolam in Nansang Township they only grow opium and ginger. That area has a lot of plains and forest. They cut down the forest for opium fields. This year corn prices dropped. So it seems opium cultivation sifted from Hopong, where it dropped, to Kolam."[78]

Other farmers also report an increase in cultivation. Said a female Pa-O farmer from Hsihseng Township:

> "We grow more opium. If we do not grow opium there is nothing else to grow. We have no flat land, and no other crops can

Figure 3: Farmgate opium prices in Eastern Shan State 2011 - 2026 (MMK per viss)



Source: Myanmar Opium Farmers Forum (MOFF)

grow. So some families grow opium on more fields. We hire plots from families who have left the village as migrant worker. We lease these plots per year."[79]

Opium prices and cultivation levels thus continue to fluctuate in Myanmar. In general, opium produced near heroin-processing sites or end markets fetches higher prices. According to MOFF,[80] prices in eastern and northern Shan State and Kachin State are 40-60 percent higher than in southern Shan. In 2024, prices ranged from 1.5 – 1.8 million MMK per viss in eastern and northern Shan State, and over 2 million MMK (870 euro) in Kachin State.

As discussed earlier, the impact of the Taliban's 2022 opium ban on Myanmar remains uncertain. The recent surge in cultivation in Myanmar began in 2020, before the Taliban decree took effect. Key factors driving this increase include renewed trader investment, international heroin demand, the socio-economic fallout from Covid-19, and worsening conflict and poverty since the 2021 coup. Most Myanmar opium is processed into heroin in Shan State laboratories and smuggled to China, and through Thailand, Laos and Cambodia to Southeast Asia and Australia.[81]



Small bottles of heroin in Kachin State (TNI)

While the Taliban ban has sharply increased opium prices inside Afghanistan – potentially encouraging future cultivation – its long-term global effects are uncertain. If the ban persists, cultivation may shift to other regions, including Myanmar, Mexico and Colombia, to meet demand in Europe and North America.

Opium and heroin consumption in Asia

The region has seen major changes in drug use patterns over the last decades. Traditionally, the drug market was dominated by smoked opium use. Countries such as Laos and Myanmar have a long history of low-risk traditional and medicinal opium consumption, particularly in poppy growing regions.[82] Heroin use emerged in the 1970s, first through smoking and later by injection, marking a shift toward more problematic use. In the 1990s, amphetamine-type stimulants (ATS) entered the market and became widespread.[83] More recently, ketamine and "happy water" have become popular, especially among young people. While ATS and newer substances dominate today's regional market, TNI research shows that opium and heroin use still persists, though overall numbers of heroin users are declining. Patterns vary widely between and within countries.

Reliable data on drug use in Asia remain scarce as there have been few national surveys. Thailand's 2019 national household survey found cannabis, methamphetamine and kratom as the most used substances.[84] The ASEAN Narcotics Cooperation Center also confirms limited prevalence data but tracks drug treatment admissions, noting that two-thirds of people in treatment were ATS users, 15% opiate/opioid users, 3.5% cannabis users and 12% polydrugs users.[85]

Most heroin production in Southeast Asia occurs in Myanmar. While some is consumed locally, a large share is exported, mainly

Addressing environmental concerns in the context of drug cultivation

Different actors have raised environmental issues in the drug policy debate. Governments often blame smallholder farmers for cutting down forest to grow illicit plants, while civil society and researchers highlight the health and ecological risks of aerial eradication by governments, using herbicides such as glyphosate. Meanwhile, climate finance mechanisms like carbon trading and public-private partnerships are increasingly promoted as funding sources for alternative development,[86] though serious ethical and environmental concerns remain, as such mechanisms rarely address the root causes of degradation and inequality.[87] Governments in the Golden Triangle – Laos, Thailand and Myanmar – often cite forest loss from "slash and burn" agriculture, yet opium is mostly cultivated by ethnic minority farmers in remote mountain areas, who have practised rotational farming for generations.

Shifting cultivation, among humanity's oldest farming systems, can be highly sustainable when managed properly.[88] Farmers rotate and fallow upland plots for six to seven years, allowing forests to regenerate and maintaining soil fertility and biodiversity.

According to the 2022 World Drug Report, opium poppy cultivation represents only 3% of morphine's total carbon footprint, while nearly 90% comes from later production stages.[89] Environmental impacts vary by context: in Afghanistan, the use of solar irrigation and agrochemicals has enabled more cultivation but also depleted groundwater sources vital to local livelihoods.[90]

In contrast, traditional smallholder poppy cultivation in Myanmar has minimal environmental impact, resembling other agroforestry systems. While slash-and-burn methods can cause some deforestation and haze, these outcomes are intertwined with wider drivers such as trade, investment, development and repressive drug control policies.[91]

Forced eradication without compensation and development support often drives farmers deeper into forests to avoid detection and replace lost crops. At the same time, land grabs and confiscations limit available farmland, forcing continuous cultivation that prevents regeneration and increases dependence on chemical fertilisers and pesticides, raising both costs and environmental risks.

Large-scale commercial plantations – rubber, palm oil, fruits, coffee or tea – are the main drivers of deforestation. Such industrial monocultures rely on hybrid or genetically modified crops, heavy use of agrichemicals, and intensive water consumption, posing far greater risks than traditional farming.

Supporting smallholder, diversified farming helps reduce environmental harm. In Shan State and across Southeast Asia, crop rotation and intercropping (e.g. with leguminous crops like peanut or soybean) enhance soil fertility and reduce pests.

Opium cultivation must not be treated solely as a law enforcement issue. Criminalisation and eradication, when not paired with livelihood support, further marginalise rural farmers and increase environmental risks. Supply-reduction efforts must integrate development support to avoid new humanitarian or ecological crises.

Finally, addressing environmental concerns in drug cultivation requires a holistic, rights-based approach: respecting local communities' rights to food, health and traditional land use;[92] ensuring their participation in policymaking; and holding corporations and investors accountable for large-scale ecological and social damage.



Preparing for khatbone opium smoking (SKT)

to China, and to a lesser extent Thailand, Laos, India and Malaysia. According to China's Office of National Narcotics Control Commission (NNCC), Myanmar remains the country's main heroin and methamphetamine supplier:

> "Out of the 1.3 tons of heroin seized in 2022, 1.29 ton originated from the Golden Triangle (about 99%, mainly from Myanmar)."[93]

Precursor chemicals such as acetic anhydride and ephedrine are illegally imported, mostly from China, Thailand and India, as Myanmar produces none domestically.

By 2006, China had reportedly become the world's largest heroin-seizing country, with more than one million registered users, most consuming heroin.[94] However, by end-2022, NNCC reported 1.1 million registered drug users, a 25% decline from the previous year. Of these, 416,000 used heroin, 588,000 methamphetamine, and 32,000 ketamine. Wastewater analysis also confirmed a significant drop in the use of all three substances.[95] TNI field research in Yunnan in 2021 confirmed a decline in heroin use but a sharp rise in ATS and ketamine, especially among young people (see section 'Heroin decline in China' below).

Similar trends are seen elsewhere in the region. According to the Research Division of the Malaysian Parliament: "The continued influx of synthetic drugs from the Golden Triangle region remains a significant threat with methamphetamine, cannabis, meth pills, Erimin-5, and ketamine being the most commonly smuggled substance into the country." The parliamentary group also found

that "as of March 2024, drug use in Malaysia had largely shifted from opiates to ATS, with methamphetamine particularly dominant."[96]

A person's drug use patterns depend on factors including age, gender, culture, income and location. According to a male harm reduction worker in Bangkok, heroin is now more common among older users, while younger people increasingly prefer ATS and club drugs:

> "In the past heroin was one of the most used drugs. Nowadays, more people use methamphetamine. The age of users is changing – from middle-aged heroin users to younger groups using ice, yaba, MDMA or ketamine."[97]

Patterns of opioid use also differ greatly across the region. Injecting drug use remains common among heroin users, sometimes combined with sedatives like triazolam, midazolam or zopiclone.[98] About 2.9 million out of 14 million people who inject drugs live in east and southeast Asia.[99] Others smoke or inhale heroin instead. Motivations for using opioids range from curiosity or recreation to self-medication for pain or economic hardship. An elderly woman from Kachin State explained how poverty and pain led her to both use and sell amounts of heroin:

> "I use heroin as a painkiller… I used to smoke opium before, but now it's hard to find. I spend about 5,000 kyats [3 euro] over three days. I also sell a little – just to buy rice bran to feed my pigs. Many here are poor. I don't make much profit, and I only sell to other elderly people."[100]

Opiate use, including heroin smoking and injection, also has a gendered dimension. In some cases, women began injecting heroin because their male partners did, and their use mirrored their partners' habits. One woman from Yangon shared:

> "My husband bought the drugs, and I followed him. At first, I used once per day; later it became three times. I was afraid of needles, but after a while, I wasn't anymore. My husband helps me inject."[101]

Such dependence and needle sharing expose women to health risks and sometimes intimate partner violence. In Indonesia, studies show women who inject diverted pharmaceuticals – such as buprenorphine – share needles more frequently than those injecting heroin, likely because HIV programmes focus mainly on heroin use.[102]

Unfortunately, women who inject drugs are still too often "described in terms of their risk for HIV, viral hepatitis and other sexually transmitted infections – with scant emphasis on their human rights and dignity."[103] A woman from the city of Pyay in Myanmar illustrates how such one-sided view affects women:

> "Women and men both feel distressed… for us, women, we sit in silence. No one helps us. Some end up in bars, some using drugs."[104]



Selling herbal medicinal plants in Wa region after opium ban (TNI)

Recreational and medicinal opium use in the region

Opium cultivation and use are deeply embedded in the social, cultural and economic life of many highland communities in remote areas of Myanmar, Laos and Northeast India.

In isolated regions with limited access to health care, people rely on opium as traditional medicine to treat common illnesses such as diarrhea, dysentery, malaria, chronic cough, high fever, fatigue and pain. Opium is also used to treat livestock diseases and to tame working elephants, buffalos and oxen. Most households therefore keep 200-300 grams of raw opium for medicinal purposes. A 30-year-old Lahu woman from Mong Ping Township, eastern Shan State, said:

> "Opium has been used as medicine for coughing and diarrhea. We bake opium and take it – it's very effective."[105]

A 50-year-old Pa-O woman from Hopong Township added:

> "Opium is essential medicine for us. We are afraid of chemical medicines. If cows or buffalos are sick, we use opium. If children are hurt, we dissolve opium and apply it. It would be good to have the right to cultivate opium as a legal crop."[106]

In Kachin State, opium is often smoked by mixing it with dried leaves in a bamboo pipe for medicinal and social use, and it is known as "khatpone". A male Lahu farmer from Mong Hsat Township explained:

> "Opium is more than a cash crop. We use it as traditional medicine and in rituals – weddings, funerals, housewarmings. It's part of our belief and religion."[107]

A 38-year-old Kachin woman from Danai Township described local practices:

> "Khatpone" smokers boil opium and mix it with dried banana leaf before smoking. It's used to treat severe diarrhea, relieve lung cancer, and stop bleeding. It's also part of social life – used in dowry negotiations



Packages of raw opium in Kachin State (SKT)

> or community disputes. Christian communities no longer practice these uses though."[108]

Smoking opium is an elaborate social ritual with few serious negative consequences for most users. Among many ethnic groups, it remains a symbol of hospitality and respect, offered to elders or guests at ceremonies.

A 48-year-old Naga man described:

> "Naga share "clothed opium" during weddings or funerals. About half of our communities still follow this custom, even though Christian Pastors discourage it."[109]

A 46-year-old Naga woman from Sagaing Region added:

> "Our village lives mainly from opium farming – about 200 acres in total. Most of it is consumed locally; some goes to India to tame elephants used in logging."[110]

Opium is also used in offerings to ancestors and guardian spirits, believed to bring health, prosperity and protection. Among Kayan communities in southern Shan State, it is thought to provide good luck in hunting and shield people from evil spirits.

Given its long history, opium has become an integral part of livelihood, culture and spirituality for many ethnic groups. Many users also see it as less harmful than heroin, as explained by a 40-year-old male Kachin farmer from Sumprabum Township:

> "Being dependent on opium doesn't stop people from working. They grow what they smoke, so they don't need to steal or cheat like heroin users. Opium also plays an important role in our village customs."[111]

Traditional and medicinal uses also persist in northeast India, particularly in Arunachal Pradesh, where opium is used in "pooja" (ritual prayer) among the Mishmi people. One expert compared opium use there to wine consumption in Europe – socially accepted and integral to community life. Farmers in Chaglagam reported using opium for stomach and body pain, high blood pressure and mental fatigue.

In northern Laos, opium cultivation and use remain common among Hmong communities. Cultivation usually takes place on small plots for household consumption. A local government official in Luang Namtha Province, quoted by RFA, explained:

> "Ethnic Hmong villagers in remote areas continue to grow opium poppies due to long-held beliefs about its medicinal properties… There is much local use, and not enough rehabilitation centers. There are still a lot of people who use opium as treatment when they are sick."[112]

Another Lao government official from Xieng Khouang Province confirmed that Hmong farmers grow opium for personal use, not for sale, and the quantities remain small.[113]

The heroin epidemic in Myanmar

In the last four decades, the number of drug users in Myanmar has risen significantly. From the 1980s onwards, drug use patterns changed dramatically from smoking opium to smoking and injecting heroin. The shift occurred partly because heroin had become widely available, was potent, relatively inexpensive, and easy to consume. By the 1990s, heroin had become the dominant drug in Kachin State, northern Shan State, and larger cities such as Mandalay and Yangon. Opium use persisted mainly in eastern and southern Shan State and in Kayah State (as discussed earlier in this chapter).

By 2000, the rising number of people who inject drugs (PWIDs) and the accelerating HIV/AIDS epidemic had become one of the most serious public-health threats in Myanmar and the wider region. Infection rates among PWIDs were among the highest in the world. High-risk behaviour was common in drug injecting teashops or 'shooting galleries', found not only in cities but increasingly in rural areas. Usually only one set of needles was available, and sterilisation of injecting paraphernalia was

rare.[114] Reliable data were limited, but trends were unambiguous.

According to a 2002 NGO report, estimated HIV prevalence among PWIDs increased from 54% in 1997 to 63% in 2000, exceeding 90% in some locations, especially in Shan and Kachin States. The same study noted that 61% of injecting heroin users shared needles and syringes. Unlike in many other countries, PWIDs in Myanmar often became infected with HIV soon after initiating injection.[115] In 2004, UNAIDS reported HIV positivity rates of 47% among PWIDs in Myitkyina and 60% in Lashio. In Yangon and Mandalay, rates were 25% and 30% respectively. Nationwide, the national Department of Health estimated HIV prevalence among PWIDs at 34% in 2004.[116] These figures mirror patterns observed in the Golden Triangle during the same period (as seen in previous TNI reports).

A 2018 study by Médecins du Monde, working in Kachin State, concluded:

> "Kachin State is one of the areas most affected by problematic drug use… Injecting drug users have one of the highest levels of the HIV prevalence in the country, reaching up to 47% in Waimaw… High-risk behaviour, low access to health care and prevention services, lack of trained human resources, strong stigmatisation and a repressive policy environment are sparking the HIV epidemic amongst PWUD."[117]

Since then, heroin use has become less common. A new generation of users – more aware of the dangers of injecting heroin – increasingly prefer ATS, particularly methamphetamine, which has become more fashionable and accessible. International organisations have expanded HIV prevention efforts, including awareness campaigns, antiretroviral therapy (ART), and harm reduction programmes. Communities of people who use drugs have also become more knowledgeable and share harm reduction practices with their peers. Yet, the need for accessible health services – including overdose prevention – remains urgent. As illustrated by a woman from Yangon:

> "After I used heroin, I overdosed, and my husband sent me to Shin Pargu hospital first… The doctor gave me more injections and the police watched me… We told



Penicilline bottle with heroin in Myanmar (DPAG)

Anti-retroviral treatment (ART) under threat in Myanmar

The recent shutdown of USAID programmes has severely disrupted HIV, hepatitis C, and harm reduction services worldwide, with Myanmar hit especially hard. For years, antiretroviral therapy (ART) has been distributed mainly by NGOs funded by donors such as the Global Fund and USAID – providing essential support for people in conflict zones and border areas. Since that time, other Western donors have also decreased funding to Myanmar.

Additionally, in July 2025, the junta-controlled Ministry of Health issued a directive restricting ART distribution to government facilities only, effectively forcing NGO clinics to close and already understaffed hospitals. With NGO clinics under threat, a range of lifesaving services are becoming increasingly inaccessible, including free blood testing and free distribution of Pre-exposure prophylaxis (PrEP) – a medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. Patients must now re-register with government facilities, raising fears about privacy, stigma and the risk of being publicly identified as HIV-positive.[118]

> them I mistakenly used my husband's methadone bottle. I think it would be good to have naloxone easily available at the hospital. If so, more human lives can be saved."[119]

Notwithstanding the rising popularity and falling prices of ATS such as methamphetamine pills, heroin use remains prevalent in certain parts of Myanmar – in line with trends discussed earlier. This is especially the case in Kachin and northern Shan States and the Sagaing Region, but also in some urban areas such as Yangon. Although in some parts of the region heroin is mainly used by an older generation of drug users who started using in the 1980s or 1990s, many younger people in northern Myanmar also use heroin, with some having started recently. According to the MDM report: "[Kachin State] is reported to have a greater proportion of young injectors (under 25 of age), who have started to use drugs in their early 20s."[120]

In Yangon, people who use drugs interviewed in 2024 said that yama and heroin were the most popular drugs, alongside cannabis and crystal methamphetamine. Respondents reported arrests during Covid-19 restrictions, while the 2021 military coup was followed by easier access to drugs, as law enforcement focused on arresting pro-democracy activists. They believe that drug use increased due to greater availability, the socio-economic fallout of Covid-19 and further widespread depression linked to the coup. According to a 20-year-old woman from Insein Township:

> "Heroin is more expensive than WY [methamphetamine brand]... A "Shwe Thamin" ["Golden-Dear"] bottle with heroin is 35,000 Kyats (15 euro). They divide it into small cups, using syringe caps and sell for around 3,000-4,000 Kyats, but for 3,000 kyats the amount is quite small."[121]

A 21-year-old man from the same area confirmed these prices, and added that increasing drugs use is closely tied to worsening socio-economic and mental health problems following the 2021 coup:

> "The most commonly used drugs here are WY and heroin. The current price of heroin is 35,000 kyats per Shwe Thamin bottle, a traditional medicine about the size of 2/3 of your pinky finger. It used to be around 25,000 kyats (10.50 euro) per bottle in 2019, but the price went up in 2024. Cheaper options are available for 4,000 to 5,000 kyats per syringe cap. You know those come

Table 2: Decreasing heroin prices in Lashio 2020-2024 (in MMK)

Type of drug	2020	2021	2022	2023	2024
Heroin (1 penicillin bottle)	8,000	8,500	8,000	7,000	6,000
Heroin (1 soap container)	120,000	120,000	100,000	90,000	80,000

Source: Interview with drug user from Lashio[122]

> from medicinal use... It is true that drug use has increased. It's because of worsening economic conditions. It's because of a lack of jobs and opportunities, leading people to seek escape through drugs."[123]

According to a 44-years-old Bamar man from Kyemindine Township:

> "Yama or "athee" ["fruit", Burmese slang for methamphetamine], marijuana and heroin are the most popular drugs here. I started using drugs when I was 25 years old, mostly heroin. I snort it twice a day, a quarter of a penicillin bottle each time. A bottle is 35,000 kyats. When buying in bulk, penicillin bottles are most common. I don't like yama but I use it occasionally."[124]

He also believed that declining prices and lower quality have contributed to increased drug use, and argued – as also heard in earlier TNI research – that the post-coup authorities may tolerate cheap drug availability:

> "The government is tactically trying to keep people from noticing what they're doing. I think the increase in drug abuse is due to the lower prices in the market. All drug prices are decreasing. Heroin that used to cost about 100,000 kyats (43 euro) now costs around 35,000 kyats." [125]

In many other parts of central Myanmar, heroin use has declined over the past decade and in some areas been replaced by methamphetamine use. According to 45-year-old woman from Pyay:

> "In the past, weed and heroin were used most common. Today WY and weed are most used."[126]

Drug users in Pathein in the Ayeyarwady Region, reported that WY and marijuana are dominant. A 25-years-old male security guard noted: "Other drugs aren't used much... heroin is dangerous, so not many people use it."[127] Similar patterns were found in Mon State and Tanintharyi Region, where kratom, WY and ice are the primary drugs, with heroin reportedly unavailable."[128]

In northern Myanmar, the situation is markedly different. Shan State is not only the largest opium-producing region in the country but also hosts the majority of heroin and methamphetamine production facilities. This is also a conflict-affected area with multiple armed actors, some involved in drug production and trafficking (see text box "Drugs and conflict" in the Discussion and Conclusion chapter). As a result, opium, heroin and methamphetamine are readily available at relatively low prices. A recent study on Shan State found that in some border towns: "the selling and buying of drugs ... is conducted quite openly, like selling vegetables at the market."[129]

In Lashio, heroin is sold in penicillin bottles and soapboxes, with increasing availability and falling prices. According to a 40-year-old Bamar man who recently fled Lashio and is now an Internally Displaced Person (IDP) in Yangon:

> "Yama and heroin are most commonly used [in Lashio]. Opium is rare. I started using heroin at 17. After the military seized power, drugs became more available. Heroin is 6,000 kyats (2.50 euro) per penicillin bottle and 80,000 kyats (34 euro) per soap container. Drug use has increased because they're easier to buy and cheap." [130]

As mentioned earlier, Kachin State is also a hot spot of drug use, especially heroin injection. Users report that since the 2021 coup heroin has become more easily available and prices have fallen. Hopin, on the railway line between Mandalay and Myitkyina, is considered a major trading point. According to a local researcher:

> "Hopin is one of the main drug-dealing towns in Kachin State, with heroin, opium and yaba for sale. It supplies the Indawgyi region and Hpakant's jade mines. Around 70% of the local income flow is based on drugs. Under the democratic government the market was partly frozen but after the coup it reactivated, and the number of users has risen."[131]

A jade dealer in Hopin who uses heroin echoed this:

> "I first used heroin for fun, then became addicted. I smoked for three months, then started injecting. If I can't use it, I lose appetite, feel pain and cough. Injecting three times a day costs me 15,000 MMK [6.50 euro]. Methadone didn't satisfy me and isn't always available. After the coup, heroin became easy to access everywhere."[132]

A source in Indawgyi reported increased availability and rising use, even as prices rose:

> "People use one-and-a-half to three penicillin bottles per day, mostly injecting. Heroin wasn't very available in 2019-2020, but after 2021 the number of users and dealers increased. Since 2022 the drug user community has grown much bigger."[133]

The same source said methamphetamine prices have fallen and use has spread, including some medicinal use:

> "In early 2021 methamphetamines were hard to get here, but since late 2021 they've become more available. Most users are youths and gold miners. Some paralyzed or ill people use them for medical reasons."[134]



Opium harvest in Kachin State (SKT)

Table 3: Opium, heroin and yaba prices in Hopin (in MMK)

2013-2018

Type of drugs	2013	2014	2015	2016	2017	2018
Opium (5 tickles)	100,000	100,000	80,000	80,000	120,000	120,000
Heroin (1 Penicillin bottle)	25,000	24,000	24,000	20,000	20,000	18,000
Yaba (1 pill)	25,000	20,000	18,000	18,000	18,000	9,000

2019-2023

Type of drugs	2019	2020	2021	2022	2023
Opium (5 tickles)	95,000	100,000	90,000	120,000	160,000
Heroin (1 Penicillin bottle)	12,000	15,000	9,500	8,000	7,000
Yaba (1 pill)	6,000	4,000	3,500	2,000	800

Source: Interviews with opium, heroin and yaba users in Hopin, January 2024

Indawgyi has also some opium use and cultivation. According to the same source:

> "In our village 30 households grow opium. They sold freely in 2019-2020 but stopped after the Pat Jasan operations [see section 'Unintended consequences of eradication of poppy fields in Kachin State' below] came here, and since then opium farmers and dealers do not dare to carry out their local opium business. So, since then, opium is coming from other places, such as Kanpaiti and Sadung in eastern Kachin State and from other places in northern Shan State. Some people use opium for recreational or health purposes. There is also opium use by daily workers here. They mainly mix it with banana leaves and smoke it with a bamboo pipe. This is locally known as "khatbone". The opium in our village can last for at least 6 months. But the opium coming from other places like eastern Kachin State and northern Shan State can last longer, for over a year. Opium farmers here think this is because of the different climate and physical situation there."[135]

There is also a perception among some people in Kachin State that when people mainly used opium, drug-related problems were fewer. By contrast, many express strong concerns about the growing number of young heroin injectors.[136] A 45-year-old Kachin poppy farmer and artisanal miner near Putao explained:

> "The older generation smoked "khatpone" opium for medicinal purposes and lived long lives. But young people today live short lives because they drink alcohol with Chinese yeast and inject heroin. Many lost their futures after schools closed during Covid-19 and after the coup. They are vulnerable to alcohol and drugs.[137]

In Washawng, a village known for drug selling in Waingmaw township, Kachin State, heroin and opium remain most common. Heroin is sold in penicillin bottles of around 3 grams for 20,000-25,000 kyats (8.50-10.50 euro) – lower than the 35,000 to 40,000 kyats (15-17 euro) two to five years ago per penicillin bottle of heroin. Opium currently costs 5,000 kyats (2 euro) per quarter tickle (4 grams: 1

tickle is 16 grams), nearly double the Covid-19 era price. Respondents also reported more difficulties finding heroin due to fear of arrest and the shift in selling locations.[138]

Unintended consequences of eradication of poppy fields in Kachin State

The scale and severity of the injecting heroin and related health crisis in Myanmar, especially in Kachin and northern Shan States, caused great concern among local communities. In 2014 "Pat Jasan" ("Prohibit Clear") was formed to combat the worsening drug problem. The self-appointed committee decided to take law enforcement into their own hands, arguing that the government was failing to stop the flow of harmful drugs into their areas. According to one study:

> "Pat Jasan arose in the context of intersecting crises linked to protracted armed violence, extractive development and the 'slow violence' associated with widespread drug use. It was a response to a perceived vacuum of policing and the limitations of internationally supported harm reduction measures to recognize or address the magnitude of the problem."[139]

Pat Jasan members, often dressed in military-style uniforms and armed with sticks and batons, arrested and beat drug users, placing some in forced treatment camps. They have also sent teams into opium-growing areas to eradicate poppy fields. According to a former Pat Jasan spokesperson:

> "The core aim is to liberate people from drug abuse. Raising awareness, taking action, detoxification, and destroying poppy plants are our main activities. Taking action means arresting drug users and referring them to detoxification centres or to prosecution under the anti-drug law... If we don't take measures, our generation will become extinct."[140]

The Pat Jasan has been praised by some Kachin activists for addressing drug problems, but criticised by others for human rights violations and for failing to provide services to marginalised communities, including drug users and poppy farmers. Their eradication

Table 4: Opium, heroin and yaba prices in Indawgyi 2019-2023 (in MMK)

Type of drugs	Quantity	2019-2020	2021-2023
Opium (retail)	1 Rawng = 40 tickle	60,000	70,000
Opium (wholesale)	1 Rawng = 40 tickle	50,000	70,000
Opium (wholesale)	1 viss = 40 Rawng	2,000,000	2,800,000
Heroin (retail)	1 penicillin bottle	7,000	15,000
Heroin (wholesale)	1 penicillin bottle	5,000	8,000
Yaba WY (yellow, green and pink colors)	1 pill	1,000	500
Yaba WY (dark red color)	1 pill	500	400

Source: Interviews with opium, heroin and yaba users in Indawgyi, January 2024.

efforts also led to open conflict with opium farmers and militia groups.[141]

The main response to reducing opium cultivation in Kachin State has been eradication. Eradication campaigns have been carried out by central authorities, local militias and Pat Jasan. However, as TNI research shows, its impact on cultivation levels has been limited, while generating multiple negative consequences. It is important to note that opium cultivated in Kachin State is not used to produce heroin in Myanmar. Opium harvested in western Kachin State is too wet; and opium from eastern Kachin State is mostly consumed locally. In both contexts the opium is often mixed with dried leaves and smoked through a bamboo pipe ("khatbone").

Farmers at a global forum analysing the impacts of eradication-based drug policies warned:

> "Forced eradication – chemical, biological, manual or any other form – of crops produced by small farmers is contrary to human rights, causes diverse forms of conflict, expands countries' agricultural frontier, leads to environmental degradation, causes food insecurity and destroys rural economic survival strategies. It aggravates social problems – as well as problems related to health and internal security – increases poverty, leads to displacement of affected populations, delegitimizes state institutions, militarizes local communities and is a form of undemocratic intervention, forcing those impacted to seek survival strategies in other informal or illicit economic activities and in some cases pushes people to take more radical positions. Finally, forced eradication is counterproductive with regards to sustainable development."[142]

A local observer who witnessed eradication in the Sadung-Kanpaiti area in January 2021 explained:

> "The level of opium cultivation has dropped by half. On the surface, you may think it is a good sign, but in reality, it has increased unemployment followed by



Raw opium, dried leaves and pipes for katbong opium smoking in Kachin State (SKT)

> rising social problems. Subsistence level opium farmers are 'burning out' after the price of opium dropped to the lowest point of 400,000 MMK (240 euro) per viss. People are desperate and are expecting international NGOs to be kind enough to show them the way out. The rough bumpy road is waiting ahead if no one provides assistance for opium substitution and put something to eat on their table. The most concerning issue is the penetration of heroin and yama as a substitute for opium after the opium harvest has declined and it is unable to supply local consumption anymore, as we have already seen people started using these drugs instead of opium."[143]

A 45-year-old male farmer from Sadung highlighted the corruption involved:

> "We have border guard forces, militias, the national army and police. Multi-agencies sit at the Kanpaiti Border Control facility. Eradication teams came every year but made little impact. This year, eradication was made valley-to-valley, instead of field-to-field. Last year they eradicated only one field and demanded bribes from each farmer. This year the bribe ranged from 3000 Yuan (385 euro) up to 7000 Yuan (900 euro). Instead of receiving assistance to help end poppy cultivation, farmers must pay cash to officers. We don't want to grow opium, but there is no alternative and the weather has become unpredictable."[144]

Opium eradication campaigns by Pat Jasan have faced similar problems. Local sources report that these campaigns actually have been counterproductive, pushing people towards more dangerous drug use. A 40-year-old man from a village between Sumprabum and Putao explained:

> "Religious and community-based vigilance groups called Pat Jasan from Myitkyina showed up here during 2018-2019 for opium eradication and threatened opium farmers. Since then people stopped growing opium, and availability decreased. But this led to people injecting heroin instead. Heroin became very easy to access after the upgrade to the Myitkyina-Putao highway, and it's now the dominant drug. The socio-economic status of people has worsened as drug use shifted from smoking opium to injecting heroin." [145]

Similarly, a 45-year-old Kachin man working at an artisanal gold mine near Putao described:

> "'Khatpone' opium smoking was replaced by heroin, which became easily available after community-based eradication teams – Pat Jasan, local police and faith-based groups – arrived in 2018. Heroin flowed freely along the upgraded highway. Processing opium takes time and you must grow it first. Supply shortages can happen due to climate or eradication. Eradication of opium sometimes pushed people to use heroin instead."[146]

Additional criticism concerns the conduct of Pat Jasan teams. According to a 26-year-old Naga woman from Danai Township:

> "The Pat Jasan campaign came again in January [2021]. Each ward had to send people, but it was ineffective because many in the team were opium users. Those users harvested the opium gum before destroying the fields."[147]

A 38-year-old Kachin woman from Danai Township added:

> "Our town is located on the Ledo Road, over 150 miles from Myitkyina. There is only one road. In the rainy season, cars cannot use it – only motorbikes. They cultivate 'clothed opium' along the stream five miles away. Opium is part of their tradition. But the harvest dropped sharply when Pat Jasan destroyed fields two years ago. The low availability of opium did not stop people from using heroin powder instead. Heroin users were everywhere and many young people died early. Some mine owners even paid labourers in heroin instead of cash. The yama epidemic also spread. Heroin and yama mostly arrived by boats along the Tarong stream. Prices

Dilemmas around development-oriented drug policies

In recent years, the international drug policy discourse has increasingly embraced the language of human rights, sustainable development, environmental protection, and indigenous and cultural rights. On paper this is a step in a positive direction, but the situation on the ground is often far more complex. In reality, crop eradication still occurs, violating people's right to food, livelihood and other essential needs. Though well documented, the traditional and medicinal uses of prohibited crops such as opium, cannabis and coca remain largely unrecognised and are criminalised. Meanwhile, rural working people are often excluded from decision-making processes that affect their day-to-day life – drug policy related or otherwise. These contradictions raise difficult questions about the actual impact of development-oriented drug policies.

One such approach, Alternative Development (AD), aims to transition farmers from illicit to licit livelihoods. But AD projects often face significant structural and political limitations, particularly when tied to agribusiness or extractive economic models, that have historically contributed to impoverishment and reliance on illicit economies. Some of the most widely promoted AD models, such as those initiated in northern Thailand with a focus on self-sufficiency and community participation, are difficult to replicate elsewhere. They require substantial financial and political investment, long-term stability, and adherence to proper sequencing.[148] It is also important to note the possible balloon effect where such efforts contribute to displacement of opium cultivation from northern Thailand to neighbouring Myanmar, as discussed earlier and in previous TNI reports.

Moreover, many so-called "environmentally harmful" practices by small farmers, such as overharvesting forest products or cutting down forests for illicit cultivation, must be understood within a context of systemic marginalisation. When customary lands are grabbed, or when opium cultivation is forcibly halted without viable alternatives, communities are pushed to extract what they can from dwindling resources. Rather than addressing these root causes, policies too often disproportionately blame small-scale actors for drug-related or environmental harms, whilst powerful players in supply chains and policy circles remain unchallenged.

Meanwhile, key strategic dilemmas prevail. What are development-oriented drug policies truly aiming to achieve? Is the priority to eradicate illicit cultivation and with the objective to shrink drug markets, or to improve health, welfare and human development indicators for vulnerable populations? Without prioritisation of the latter, there is a risk that development-oriented drug policy becomes another form of control and accumulation, serving powerful interests rather than affected communities.

dropped by 60% around 2020. You could get yama tablet for 500-1000 kyats (30-60 euro cents)."[149]

Heroin decline in China

Interviews with former heroin users in China's Yunnan Province in 2021 show a similar trend to the one described earlier. Most heroin users interviewed are now in their 40s and started using heroin in the late 1990s and early 2000s. This older generation is slowly decreasing as users switch to methadone or stop using, partly due to reductions in quality and availability, combined with increasing prices, especially during Covid-19. Among the younger generation, "xiaoma" (methamphetamine) or "magu" (methamphetamine tablets), are now most popular.

China initiated a pilot methadone programme in eight counties in 2004, and ten years later this was up-scaled to over 750 sites in 28 provinces and municipalities.[150] Concerns have been raised over relapse rates, and several methadone users interviewed indicate they still use heroin occasionally. As seen in Myanmar, similar patterns of intermittent heroin use occur despite treatment. According to a 2019 study on China's methadone maintenance therapy (MMT) programme, the number of individuals receiving MMT increased from some 3,000 in 2004, peaked at 208,000 in 2012, and then decreased to 187,000 in 2015, covering 6% of total registered Chinese drug users. The same study concluded that: "the Chinese MMT program has been effective and cost-effective in reducing injecting risks and HIV/HCV related harms." [151]

A 48-year-old male heroin user from Hubei Province explains why he thinks heroin use has decreased:

> "It is true that heroin use has decreased. Many people have experienced the harm which drugs cause. The government has made many efforts to spread awareness about drug use, and people now understand more about the harm of drugs,



Methadone clinic in Yunnan Province, China (TNI).jpg



Ex-poppy farmer growing coffee in southern Shan State (TNI).JPG

including HIV and blood related illnesses. Stigma is widespread and it is hard to find jobs. Drug use can even affect the next generation, as children and relatives also experience consequences."[152]

A 46-year-old woman from Yuxi city in Yunnan Province relates how she began using heroin and later entered methadone treatment, noting that young people today prefer other drugs:

> "I started using heroin when I was 22 years old. I was in a bad emotional state and my friend said that injecting it would make it easy to fall asleep. I used it twice per day and each time I would take 0.1 gram. Previously I would only inject heroin but now I snort it. At the moment I take methadone daily. If I cannot use as much as I would like, I feel uncomfortable, I relapse quickly. Now I only take heroin occasionally.
>
> The most commonly used drugs here are heroin and xiaoma, mainly through smoking. The group that uses traditional illicit drugs is gradually decreasing. Normally people buy and take heroin in a group at home. Since Covid-19, the price is very high and it is hard to get. People therefore rely more on methadone. Nowadays people at entertainment venues and casinos use newer drugs. Wealthy business owners like to use xiaoma. Young users also increasingly prefer xiaoma."[153]

This picture is confirmed by a 43-year-old woman, also from Yuxi City:

> "I started using heroin in 1995, when I was in a bad emotional state after breaking up with my boyfriend. Previously I snorted drugs, now I inject. Now I only take it occasionally and most of the time I use methadone. I feel uncomfortable if I cannot get as much as I would like.
>
> People at entertainment venues and casinos use xiaoma more often, and only people of the older generation take heroin. Female sex workers prefer xiaoma. Previously the people who used drugs were born around the 1970s, whereas now many users are younger and prefer xiaoma." [154]

A similar trend is observed by a 47-year-old man from Lingchang city, Yunnan Province:

> "I have used heroin since 1995. I first tried it with friends. I smoked heroin three times a day at that time. Sometimes I also used diazepam. I used to only smoke but now I mostly inject. If I cannot access heroin, I feel unwell and start craving it. I think many people experiment with different drugs in social settings. Among the students and women, magu is more popular. Younger and wealthier people also experiment with newer substances."[155]

The effects of heroin and methamphetamines differ significantly, and preferences vary. According to a 38-year-old woman from Lingchang city:

> "The first time I used heroin was in 1998. I tried it with friends and quickly became addicted, eventually injecting daily. But now I have stopped heroin and I am on methadone treatment.

Different types of drugs suit different situations: people who enjoy lively environments tend to use magu, while those who prefer quiet settings often use heroin. Magu is common among students, women and drivers who need to concentrate. Heroin is usually injected, while magu is smoked."[156]

Several heroin users reported that they were introduced to the drug by friends. Many began by snorting it, but later switched to injecting. Heroin being highly addictive, withdrawal symptoms can be severe. A 48-year-old man from Xiangyang City in Hubei Province explains:

> "I started using heroin around 2000. Now I think my friend misled me; I was curious and it quickly spiraled out of control. Now I really regret it. I moved from snorting to injecting and began using daily until I ran out of money. Cravings dominated my life and I felt desperate when I could not find heroin.

Fentanyl and public health crises in North America

One of the most striking developments of the past decade has been the sharp rise in the production, trade and consumption of fentanyl (a synthetic opioid) and its analogues. Seizures of fentanyl-related substances increased nearly fifty-fold between 2015 and 2019, and more than 6,000-fold since year 2000,[157] almost entirely in North America. Fentanyl trafficked into the United States has long been understood to originate primarily from China. Direct shipments reportedly declined after Chinese authorities scheduled fentanyl and its main analogues in 2019, following sustained US pressure.[158] As seen elsewhere, however, regulatory changes were quickly circumvented, with trafficking organisations shifting exports via Mexico in collaboration with major drug cartels.[159]

Concerns around fentanyl became further globalised following the reported seizure of 3,700 litres of methylfentanyl in Kutkai, Shan State, in May 2019. Initially described as the largest-ever synthetic drug haul, it was widely interpreted as evidence of diversification of drug production in Myanmar.[160] Yet the veracity of the seizure has been informally questioned, although neither UNODC nor the Central Committee for Drug Abuse Control (CCDAC) has issued a formal clarification.[161] The quantities reported strongly suggest an error in the identification of the substance: 3,700 litres of methylfentanyl would far exceed global demand and could theoretically kill millions by overdose. The operation occurred in territory controlled by a militia allied with the Myanmar military, known as the Tatmadaw (Sit-Tat), where another large seizure had taken place a year earlier. As discussed elsewhere, such areas offer the kind of "predictable insecurity" in which methamphetamine production has flourished (see also section on "Drugs and conflict" in Chapter 6).[162]

Meanwhile, the United States has experienced a dramatic rise in fatal overdoses, largely linked to fentanyl-adulterated heroin, cocaine, and methamphetamines. Tens of thousands die each year,[163] with more than 100,000 overdose deaths recorded in 2021 alone.[164] As noted in earlier TNI analyses, this public health crisis is closely tied to long-standing racial inequalities. A study of the University of California, Los Angeles,[165] found that between 2019 and 2020 overdose deaths increased by 49% among African Americans, compared with 26% among white people, while Indigenous Americans experienced the highest mortality rate: 41.4 deaths per 100,000 in 2020, a 43% increase from the previous year."[166]

Similarly in Canada, opioid-related deaths have been increasing since 2016. Canada recorded more than 7,000 deaths in 2021.[167] In Alberta alone, 900 people died from drug overdoses between January and July 2021.[168] In British Columbia, more than 85,000 people are said to be at risk of overdose every day, prompting debates over a radical city-level experiment to provide state-tested fentanyl to people who use drugs.[169] This aligns with civil society and community-led calls for expanded harm reduction and health interventions, including supervised consumption sites,[170] drug checking services, distribution of naloxone, as well as safer supply schemes.[171]

Following sustained demands from health experts and people who use drugs in 2020, Canada launched ten safer supply pilot projects in three provinces (British Columbia, Ontario, and New Brunswick) in that same year. Participants could receive opioid

replacement medicines, such as tablets of hydromorphone and, to a lesser extent, injectable hydromorphone, fentanyl patches or oxycodone. Methadone and some stimulant replacements (such as methylphenidate and dextroamphetamine) were also offered. In addition to prescription medicines, projects provided housing, income and legal support, and help with administrative needs (such as health cards and IDs). Based on an evaluation conducted from December 2020 to March 2021, participants stated that they "have addressed health issues related to drug use, mental health and chronic diseases", "are eating and sleeping better", "are no longer engaged in survival sex work", "have more money and no longer have to hustle for drugs", among other improvements.[172]

> Now most people use ice. Heroin costs 700-800 yuan [85-100 euro] per gram, crystal meth 300-400 yuan [35-50 euro]. Ice is mostly used socially, and its use has spread among young people, including recent university graduates. Heroin is mostly injected, whereas crystal meth and magu are usually heated and inhaled."[173]

Users in China report rising heroin prices and declining quality. A 43-year-old woman who uses drugs from Yuxi City explained in 2021:

> "Heroin now costs 1000-2000 yuan [125-250 euro] per gram, and methamphetamine about 350-400 yuan [45-50 euro] for 10 tablets. Both are hard to get. These come from Myanmar, but now there are many impurities and the quality is very poor. It used to be easy to buy and cheaper. I used to take a lot because I was addicted, but now I only use it occasionally."[174]

A 47-year-old male heroin user from Lingchang city described a similar situation, linking it to stricter law enforcement and Covid-19 measures:

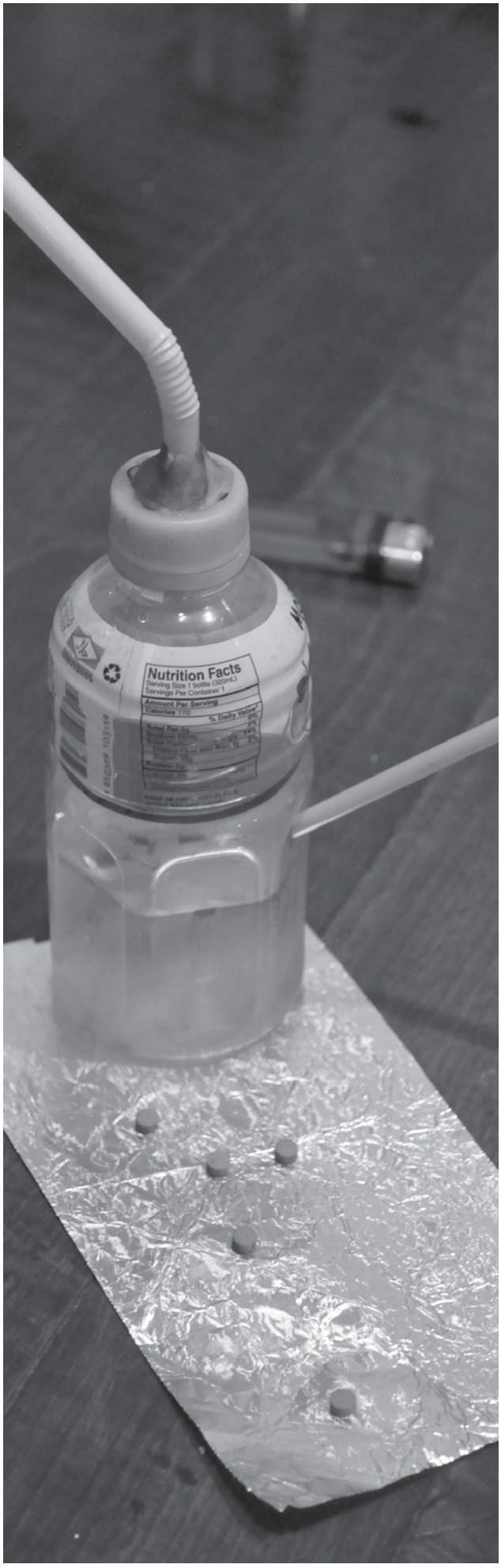
> "The price of heroin has nearly doubled from 200 to 300 yuan per gram to about 500 yuan. It comes from Myanmar, but the purity is much worse – sometimes mixed with things like rat poison that causes headaches after injecting. It is harder to obtain because police are cracking down more, and border closures during Covid-19 made it worse. The risks are higher now. Since Covid-19 began, many users have reduced their intake, turned to alcohol or diazepam, or tried to quit at home."[175]

Covid-19 restrictions, including stay-at-home orders, also affected drug markets. A 38-year-old woman from Lingchang noted:

> "The most popular drug here is ATS tablets, then heroin, then crystal meth. They all come from Myanmar. Supply has dropped because dealers are being arrested, and the quality and potency are worse. Prices have risen: heroin was 300-400 yuan per gram in 2019, but during Covid-19 it reached 600-700 yuan. Some people switched from smoking to injecting, which is even riskier. Users cope by cutting down, taking methadone, or drinking heavily. There are no other options under movement restrictions."[176]

In Hubei Province, a 48-year-old man observed a shift from heroin toward ice (crystal methamphetamine) due to cost and availability:

> "I first used heroin, but it became too expensive so I replaced it with crystal meth. Most of the people who once used heroin are switching now. Heroin is 700-800 yuan per gram, while crystal meth is 300-400 yuan. Young people in particular are using more meth. The purity is lower than before, so people take higher doses – but meth is cheaper and easier to get."[177]



Water bottle and aluminium foil used to smoke methamphetamine (TNI)

3. The ATS Boom and Diversification of Synthetic Substances

This chapter examines recent shifts in the amphetamine-type stimulants market in Myanmar and the wider region. It outlines the resilience and continued expansion of methamphetamine production amidst political instability, economic decline, and intensified enforcement. Drawing on interviews with people who use drugs, traders and community actors, it highlights changes in consumption patterns, the emergence of new trafficking routes, and the different roles of actors involved. Building on earlier TNI reports, the chapter illustrates how repressive drug control measures have failed to curb ATS markets and have instead deepened harms for affected communities.

While the opiates market initiated its decline in the late nineties in Southeast Asia, the production, trade and use of ATS – in particular methamphetamine – have followed a markedly different trajectory. Far from being a novel phenomenon, the ATS boom began more than 20 years ago and has since been documented across the region.[1] ATS were initially found almost exclusively as methamphetamine tablets or "yaba", but crystal methamphetamine ("ice" or "shabu") later became common. More recently, ATS such as MDMA (in crystal or pill form, commonly known as "ecstasy"), and other synthetic substances, including ketamine and "Happy Water", are gaining increased popularity in Southeast Asia.[2]

As discussed in the previous chapter, few reliable data exist on drug use trends and patterns in Asia, as only few national drugs use surveys have been conducted, and even in countries that have them, methodologies are sometimes questionable.[3] Instead, governments often rely on indirect indicators, typically data from drug treatment programmes or official drug-user registries, leaving out significant numbers of people who use drugs who remain less visible.

In Vietnam, for example, the reported percentage of ATS use among registered

drug users rose from around 10% in 2015 to 75 and 80% in 2019 and 2020.[4] However, categorisation changed from 2021 onwards: registered drug users are no longer grouped into two main categories (ATS and "other drugs") but into more specific substance groups. By 2024, amphetamine users reportedly comprised about 25% of registered drug users. This shift makes comparison over time difficult and, because registration may trigger various consequences (e.g., compulsory rehab, loss of privacy), many users avoid registering voluntarily, further limiting the reliability of registry-based data.[5] Meanwhile, reported rises in methamphetamine use in Cambodia and Laos is based mainly on treatment admissions,[6] while in these and other countries, changes in drug use patterns are often documented through "expert perception".[7]

Thailand and Indonesia are among the few countries carrying out national drug use surveys. The 2019 Thai National Household Survey on Drug Use found that the number of methamphetamine tablet users had increased from 1.4 per 1,000 population in 2007 to 13 per 1,000 in 2019. Consumption of crystal methamphetamine, ketamine and MDMA reportedly rose significantly in 2021, the same year in which around 3% of young people aged 10 to 18 reported using of methamphetamine tablets, crystal methamphetamine and/or MDMA in the previous three months.[8]

More recently, Thailand's Office of the Narcotics Control Board (ONCB) stated that in 2024, "about 1.5 million Thais use methamphetamine, with some 220,000 experiencing mental health issues", and "around 330,000 requiring treatment."[9] In Indonesia, government data from 2021 show that ATS (covering crystal methamphetamine, ecstasy, amphetamine, dexamphetamine and Adderall) accounted for around 25.7% of illicit drug use, serving as the second most commonly used substance after cannabis (estimated at around 41%).[10] These data were obtained through quantitative surveys among respondents aged 15 to 64, representing



Different methamphetamine pills available in Myanmar

What are amphetamine-type stimulants (ATS)?

Amphetamine-type stimulants (ATS) refer to a category of synthetic substances derived from the chemical compound alpha-methylphenethylamine, more commonly known as amphetamine. First synthesised in the late 19thcentury, amphetamine's key precursor is ephedrine, now mostly synthesised but historically extracted from ephedra plants.[11] There are numerous ATS substances, ranging from prescription medications, such as Adderall and dextroamphetamine, to recreational drugs like methamphetamine and MDMA. Though united as stimulants derived from amphetamine, their effects vary. Aside from use as a recreational drug, amphetamine has long been manufactured to treat medical conditions such as asthma and obesity, and to serve as performance-enhancing drugs for athletes and people diagnosed with attention deficit hyperactivity disorder (ADHD). Its use during the Second World War to enhance military performance further expanded production and demand.[12] Such applications paved the way for numerous amphetamine derivatives. Like caffeine and cocaine, amphetamine is a stimulant acting directly on the central nervous system, enhancing energy and alertness while increasing heart rate, respiration and blood pressure. Many ATS drugs also diminish appetite and reduce the need for rest, while boosting confidence and task performance.

MDMA is sometimes referred to as an empathogen, as it can enhance feelings of connectedness, emotional empathy and prosocial behaviour.[13] These properties contribute to MDMA's emerging role in novel psychotherapy approaches.[14]

Methamphetamine is associated with typical stimulant outcomes, including heightened stamina, productivity and, for some users, increased sexual desire. Methamphetamine comes in pill or tablet and crystal forms. Concentrations vary considerably. Methamphetamine tablets – known as WY, "yaba" or "yama" ("crazy drug" or "horse drug" in Thailand and Myanmar) or "xiaoma" in China ("little horse") – typically contain around 20-30% methamphetamine hydrochloride, with the remainder consisting of caffeine and other adulterants.[15]

Crystal methamphetamine ("ice" or "shabu") generally contains over 90% of methamphetamine hydrochloride,[16] and is therefore stronger and potentially more addictive than tablets. Both forms are typically inhaled in Southeast Asia, often by heating the substance on foil and inhaling the fumes through improvised bongs or pipes.[17] With the rise of crystal methamphetamine, injecting use has also increased, particularly in Thailand. Intravenous drug use is less is notable because there are no fumes involved. Dosage is also higher, so users administer the drugs fewer times a day.[18]

63,348 households across the country[19] – a relatively small sample in a country of over 240 million people.

Apart from being incomplete, these drug-related statistics often ignite public health and wider social concerns, especially when translated into sensationalised headlines across the region. However, they provide little understanding of the lived experiences of people using these drugs – experiences that are more complex than numerical indicators can capture, as explored throughout this chapter.

The penetration of ATS – in particular methamphetamine – into regional drug markets and the gradual shift from a drug economy traditionally dominated by opiates (mainly opium and heroin) towards one increasingly driven by ATS represents a further textbook example of substance "displacement", also referred to as the "balloon effect". This shift is partly linked to drug supply control efforts against other substances, in this case traditional opiates. International pressure and opium bans imposed by several armed groups in Myanmar contributed to declining levels of opium cultivation and heroin production in the region, until roughly 2020 (see previous chapter). At the same time, a large methamphetamine market rapidly developed across Southeast Asia. The sharp increase of manufacturing sites in areas where opium was traditionally cultivated and heroin produced, such as Shan State in Myanmar,[20] can thus be viewed, as being partly driven by drug control efforts themselves. Other factors also played a role, including the lucrative and mobile nature of synthetic drug production compared to opiates.

Another important factor lies in the significant socio-economic changes that have swept across the continent. To varying degrees and at different paces, Southeast Asian countries have transitioned from primarily rural, subsistence-based societies into more urban, industrial and market-based economies. Growing demand for ATS – particularly methamphetamine – for both for recreational and occupational purposes reflects this evolution and the emergence of faster-paced, more competitive societies marked by deep socioeconomic inequalities. It is no coincidence that methamphetamine use is especially common among manual and casual workers paid per task or output, whose income depends on completing as much work as possible within the shortest timeframe. Taking methamphetamine provides them the stamina and alertness needed to cope with physically exhausting tasks, often conducted in precarious conditions with minimal protection. This phenomenon has become widespread across Southeast Asia.[21]

ATS Production

Over the last decades, the focus of drug production in the region has shifted from mostly refining heroin to mass production of ATS – initially mainly methamphetamines – which quickly became highly popular. The situation intensified with the introduction of large-scale production of crystal methamphetamines in Myanmar's Shan State, known as "ice", in the beginning predominantly for export, but later on local use also spread. This production serves a large and expanding market in the region. In 2025 UNODC reported that almost two thirds of the world's amphetamine and methamphetamine users live in Asia, most of them in East and Southeast Asia.[22]

Large-scale ATS production and use in Southeast Asia started in Thailand, where in the early 1990s it became very popular. Production moved from Bangkok to outlying provinces, and by the mid-1990s crossed into neighbouring Shan State. The first to engage in ATS production there was Khun Sa's Mong Tai Army (MTA). The MTA had previously focused on organising and taxing the opium trade but ATS profits quickly attracted other armed groups and ethnic Chinese business actors.

ATS production further increased after several armed groups in Myanmar concluded ceasefires with the Myanmar military regime. These groups, such as the United Wa State Party (UWSP) in the Wa region, Myanmar



Bucket with ATS precursor ephedrine (TNI)

National Democratic Alliance Army (MNDAA) in the Kokang region and the National Democratic Alliance Army (NDAA) in the Mongla region, controlled major poppy growing regions and, following pressure from China amid rising HIV infections among heroin-injecting users, implemented opium bans. With income from "opium tax" declining, they shifted towards ATS production, forming alliances with criminal groups, mostly run by ethnic Chinese from Thailand and China. These armed groups offered autonomous territory for production; strong cross-border links to China for precursor imports; and good relations with the Myanmar military, known as the Tatmadaw, to facilitate transport of the manufactured ATS to the market in Myanmar and abroad.

In 2009 the Myanmar military government ordered all ethnic ceasefire groups to transform into Border Guard Forces (BGFs), which would organise these armed forces into separate units of some 325 soldiers, formally under Tatmadaw command. Most of the large ceasefire groups, including the UWSA, MNDAA and NDAA, refused to do so, and relations with the Myanmar regime deteriorated after this time.[23]

Another strategy of the Myanmar Army to "manage conflict" has been the formation and support for a large number of militia groups, locally known as "pyithusit". These pyithusits are officially under Tatmadaw command, and greatly benefit from the instability in the country. The main political objective of these militia and paramilitary formations is to maintain the status quo, and most of them focus on various forms of business, including drug production and trafficking, gambling, scam centers, trade in stolen cars, wildlife trade and more.[24]

In Shan State especially, a large number of militia groups profited from these arrangements since they are now favoured by the Tatmadaw to engage in all kinds of illicit businesses, including drugs production and trafficking. Mostly, the role of these groups involved providing a safe and guarded territory for production, while outside

Drugs and Scam Centers in the Golden Triangle

Myanmar, Laos and Cambodia have emerged as major bases for cyber scam centers, mostly operated by criminal networks originating from China.[25] Scam compounds are present in areas with weak governance, including in the border regions of Myanmar, Laos and Cambodia with China and Thailand. According to various reports, these criminal networks are closely connected with the state structures in the countries they work in.[26]

In Myanmar, these scam centers have been mainly located in areas controlled by armed groups allied with or under control of the Myanmar Army. This includes the now defunct Kokang Border Guard Force (BGF) in northern Shan State bordering China, and the DKBA (Democratic Karen Buddhist Army) and the Karen BGF (aka the Karen National Army) in Karen State bordering Thailand. According to the United States Institute of Peace:

> "The scam compounds in Myanmar have an additional perimeter of armed protection provided by border guard forces under the authority of the Myanmar military or its proxies. In Cambodia, speculative real estate investments – casinos and hotels left empty by the Covid pandemic's suppression of tourism – have been fortified and repurposed for online scamming in a vast web of elite-protected criminality spread across the country. In Laos, Special Economic Zones (SEZs) such as Zhao Wei's notorious Golden Triangle SEZ are the dominant mode of criminal operation."[27]

For the Myanmar Army, security is the priority, and not stopping the scam centers. As long as these BGFs and militia groups provide a useful counterforce against ethnic armed opposition groups fighting the SAC, they allow these BGFs to continue their involvement in illicit economy, such as running scam centers as well as producing drugs. Today many of these scam centers and drug production sites are public secrets and can hardly be called "clandestine operations". Myanmar law enforcement agencies have also not been allowed to take actions against these Tatmadaw-backed militias and BGFs and have been told by regime officials that this is "a matter of natural security". According to a 2023 report by the United States State Department:

> "Prosecution of criminal activity by ethnic armed groups and military-affiliated militias remains outside of police authority to investigate and regime Ministry of Legal Affairs authority to prosecute." [28]

This caused great frustration among officials in China, which was a major target for the scamming operations. As a result, China temporarily provided support to several ethnic armed opposition groups to overrun the territories of BGFs and militias in Shan State near the China border where these scam centers were located, and shut them down. This finally raised the alarm bells among Myanmar's top generals, who were confronted with a series of embarrassing military defeats and the loss of a large number of Tatmadaw bases. Only after this did the military regime of the SAC/SSPC take some limited action against scam centers located along the Thai border. Although some scam centers were (partly) destroyed, local sources say that they have simply moved to other locations.[29]

Apart from financially duping large numbers of victims online from their savings, the scam centers also employ hundreds of thousands of people to work in online scam compounds, large numbers of which are in conditions of forced criminality or victims of human trafficking. There are held under prisonlike conditions, in some cases facing beatings and torture, and originate from over 60 different countries.[30]

There are at least three ways in which scam compounds in Southeast Asia are linked to the production, trafficking and/or consumption of narcotics.

First is with respect to the actors involved in providing security to – or otherwise operating – scam centers. In the cases of northern Shan State, the Golden Triangle in Laos and in Karen State, many of the actors now involved in scam center operations have previously been the targets of sanctions and/or indictments for their involvement in narcotics. As outlined in this report (see section on drugs and conflict in Chapter "Discussion and Conclusion"), some of these accusations appear politically motivated, targeting enemies or political opponents, rather than seriously investigating the drug trade, which comes dangerously close to the upper echelons of power in the region.[31]

Among those indicted are the United Wa State Party (UWSP), which was sanctioned by the United States Treasury Department for involvement in narcotics in 2008,[32] with UWSP leaders becoming the targets of arrest warrants issued by the Chinese police for involvement in industrial scale scam operations in 2023.[33] In Karen State, Sai Kyaw Hla from the Democratic Karen Benevolent Army[34] was targeted by U.S. Treasury sanctions in 2025 for involvement in scam centers, while having also been investigated over a decade earlier for involvement in drug trafficking in Shan State. A recent report by the Karen Human Right Group also documents the involvement of the DKBA in the drug business.[35]

Meanwhile, in Laos in the Golden Triangle SEZ, Zhao Wei and his Kings Romans Group were sanctioned by the U.S. Treasury Department in 2018[36] for crimes including drug trafficking, and were later sanctioned by the UK for human rights abuses related to involvement in scam center operations.[37] Chinese court records, as documented in a programme on Chinese State TV, also detail the involvement of the Myanmar military's former Border Guard Force leaders in Kokang in both drug trafficking and production, as well as in the operation of industrial scale scam centers targeting Chinese nationals.[38] As such, in most of the scam center hotspots in Myanmar and the Golden Triangle more broadly, the same actors involved in drug production and/or trafficking are now also involved in scam center activity.

The second way scam centers are involved in narcotics is the presence of "drug bars" and easy access to drugs inside scam compounds or the SEZs hosting such compounds. Survivors repatriated from multiple scam centers in Myanmar, Cambodia, Laos and the Philippines have documented the presence of drug bars or KTV parlours inside scam centers. These facilities provide entertainment to both the compound bosses and upper-level management of the scam centers, but are also made available to "successful" rank and file scammers as a reward meant to incentivize and encourage continued good performance. In the case of the Golden Triangle Special Economic Zone and the Kokang Self-Administered Zone previously under the control of the Myanmar military, the presence of "drug bars" served a second purpose of attracting individuals into the SEZ more broadly.[39]

As China is cracking down on the use of recreational drugs such as methamphetamines, ketamine or drug cocktails such as "happy water," Chinese nationals seeking such drugs have been lured in significant numbers into places in Southeast Asia such as the GTSEZ or Kokang region. Once lured in, they are often recruited into scam center jobs, with recruiters exploiting their drug addictions to coerce them into forced criminality. These bars and the individuals targeted by this form of trafficking are largely connected to China. The Chinese police recently documented elements of this trend in a CCTV documentary that details the crimes of Bai Suocheng and other members of the Bai family in Kokang.[40]

A third way in which narcotics feature in scam center activities is their use by center management to keep scam center workers alert and active for shifts that can run 18-20 hours in length. In some cases, new arrivals in scam centers may be forced to take small amounts of crystal meth both to keep them alert, but also as part of the broader grooming process, which seeks to break down any moral or ethical opposition that a new "recruit" may have to scamming.[41]

In addition, scam centers such as those in Karen State have been accused of setting up elaborate money laundering schemes in order to launder income obtained from their illicit businesses, which includes income from their involvement in ATS production. According to an article by the BBC: "KK Park, south of the border town of Myawaddy, has been synonymous with online fraud, money laundering and human trafficking for the past five years."[42] Another report found that: "the management of compounds and the online payment channels they support (are linked) to established criminal syndicates with decades of experience in money laundering, trafficking, and illicit finance. Their involvement ensures that scam compounds are not isolated local enterprises but nodes in a broader criminal economy spanning mainland China, Hong Kong and Southeast Asia."[43]

investors are responsible for production and trafficking. As the militia groups were now allied with the Tatmadaw and given the free hand to be involved in ATS production and trade, they now became a lucrative business partner for investors. In return, militia groups pay kickbacks to Tatmadaw officers to be able to continue this business. The involvement of many of these militias in drug production and trafficking has been documented by local media and other drug observers.[44]

Measuring the expansion of the ATS market

Since the 2021 military coup in Myanmar, methamphetamine production and distribution have further increased. The junta's takeover, renewed fighting and the collapse of governance have enabled drug markets to flourish. As with earlier opium and heroin markets, methamphetamine growth reflects longstanding structural problems.

The expansion of the methamphetamine industry has also been made possible by improved infrastructure and rising border trade between Myanmar, China and Thailand. Trafficking increased via Laos into Thailand during 2020-2021,[45] before routes shifted onwards to Cambodia.[46] Recent reports also indicate expansion towards Sabah in Malaysia and into India's northeast (Mizoram and Manipur).[47] Compared to earlier years, drugs are increasingly concealed among commercial goods and transported in large consignments rather than small quantities.[48]

Reports from UNODC, drawing on national drug control data, identify Myanmar's Shan State as a key methamphetamine production



Warning signs about scam centres in Mae Sot, Thailand (TNI)

hub. According to UNODC's 2025 report on synthetic drugs in East and Southeast Asia, methamphetamine is distributed from eastern and northern Shan State to Thailand and onward across southeast Asia via land and river corridors. Kengtung is described as a "major transit location", where authorities in 2024 seized large quantities of crystal methamphetamine, ketamine and heroin.[49] Trafficking routes then continue to northern Thailand, with Laos emerging as a significant transit country. Malaysia is also becoming a key destination and trans-shipment point, with methamphetamine tablets seizures reportedly six times higher in 2024 than in 2023. Thailand alone was said to have seized a record 130 tons of methamphetamine in 2024,[50] while Indonesia reported its "biggest bust to date" in May 2025, seizing two tons of methamphetamine "from the Golden Triangle".[51]

These figures dominate policy discourse and shape media narratives, cited as evidence of expanding drug production, trafficking and successful law enforcement. However, rising seizure numbers often reflect enforcement priorities rather than the actual scale or dynamics of the market. Seizures reveal where and how authorities act, not the full extent of drug markets, and say little about their impacts on local communities.

As discussed above, reliable data on drug use trends is limited, and data on ATS production is even more problematic. Governments largely rely on seizures of precursors, pills and crystal methamphetamine, a method with clear limitations. An increase in seized tablets does not necessarily indicate increased production; it may simply reflect more effective law enforcement. Conversely, declining seizures may indicate a shift to new routes or methods rather than reduced production.

Large seizures may also stem from factors unrelated to production trends, particularly in unstable countries such as Myanmar. These include raids on groups allied with the Myanmar Army that have outlived their political usefulness, such as the Kaungkha militia group in Kutkai Township in northern Shan State; pressure from neighbouring countries on the Myanmar authorities to finally crack down on paramilitaries and militias groups producing and/or trafficking ATS across the border (such as various Lahu militia groups in eastern Shan State); or because groups producing ATS have not paid (enough) bribes to relevant authorities (see section on "drugs and conflict" in chapter 6).

Whilst drug markets in Southeast Asia are clearly expanding and diversifying, supply reduction strategies – raids, interdiction, and seizures – have not reduced methamphetamine availability or drug-related harms. Enforcement data itself shows persistent high availability and constant adaptation in production and distribution. This suggests that large-scale seizures and arrests have not curtailed production or trafficking.

This pattern is also evident in precursor control. Lab analysis performed on samples of seized crystal methamphetamine in Thailand indicated that ephedrine, pseudoephedrine and P-2-P were still widely used precursors to produce ATS up to 2023. After 2023, P-2-P was found in only 5% of samples, ephedrine and pseudoephedrine in 79%, and other unknown precursors in 16%.[52] The collapse of precursor seizures could indicate a switch to uncontrolled pre-precursors to avoid detection. This is another example of diversification in the drugs market.

Seizures and other enforcement efforts also fuel the 'balloon effect', contributing to the emergence of new substances and the relocation of production and trafficking routes across Southeast Asia. As pressure is applied in one area, patterns shift, diversifying substances and exploiting new geographies and technologies. Ketamine and other synthetics are increasingly prominent. Similar dynamics appear in the expansion of trafficking routes, such as growing Bangladesh-India corridors, alleged expansion of tableting centers in Laos, and increased flows towards Malaysia and Indonesia.[53] Methamphetamine prices have plummeted, and frontline workers note that yaba has in some cases become cheaper than food.[54]

The challenges of generating accurate estimates of ATS production are not limited to countries like Myanmar, where decades of military rule, conflict and weak governance prevent reliable data collection. As a 2015 European Union Drugs Agency (EUDA) study on ATS production in Europe notes:

> "Estimating the amount of synthetic drugs produced is extremely difficult and at present no robust estimates exist for Europe. It is possible, however, to describe the main trends and developments in this area based on an extrapolation of data from seizures, law enforcement intelligence and forensic sources."[55]

For similar reasons, providing an accurate estimate of ATS production in Myanmar and the wider region remains challenging. However, despite these limitations, it is clear that production is substantial. According to a 2019 International Crisis Group (ICG) report, "the methamphetamine business has become so large and profitable that it now dwarfs the formal economy of Shan State, and is at the centre of its political economy," although the report offers little clarification on how this conclusion was reached.[56] Nonetheless, evidence consistently points to very large-scale production. One indicator is that major seizures – such as the 2020 Kaungkha operation mentioned above – heralded as major narcotic control successes by UNODC,[57] had no meaningful impact on ATS availability or prices in Myanmar or neighbouring countries in the months that followed. As ICG correctly observes:

> "Seizures of crystal meth, as well as yaba, have increased significantly in recent years. Each massive haul tends to be presented as an interdiction victory. However, these record seizures represent the tip of an iceberg, and are therefore evidence of the scale of the problem rather than of any genuine success in addressing it. Despite massive seizures, prices of crystal meth have remained stable, a clear indication that they are a small proportion of total volumes."[58]



Heroin, ATS powder and pills confiscated by the UWSP (TNI)

New Markets: ATS trafficking from Myanmar into Bangladesh[59]

The illicit flow of drugs from Myanmar into Bangladesh has risen dramatically over the past decade. According to Bangladesh's Department of Narcotics Control (DNC), 2022 saw major yaba and crystal methamphetamine seizures in Teknaf and Cox's Bazar and other border areas with Myanmar's Rakhine State. Nearly 70% of seizures occurred in Chittagong, reflecting its proximity to Cox's Bazar, a key entry corridor.[60] According to DNC's 2025 annual report, it seized over 43 million ATS pills that year.[61] Large amounts of drugs are reportedly sold in Kalatoli, a neighbourhood in Cox's Bazar where most hotels are located. However, in Bangladesh more generally, consumers of yaba are mostly found in major cities such as Chittagong and Dhaka.

A 2025 UNODC report notes increasing methamphetamine and ketamine seizures along routes linking Shan State, Yangon and Mandalay to Maungdaw in northern Rakhine State. Methamphetamine is also allegedly smuggled into India's Mizoram, and then moved onwards to various India-Bangladesh border points.[62] With over 170 million inhabitants, Bangladesh has become a major emerging market for ATS from Myanmar. According to a Bangladesh media report:

> "The staggering increase in the seizure of yaba alone – from 800,000 pills in 2010 to 45 million pills in 2022 – is an alarming manifestation of the incredible growth of illicit drug trade in the country over the past decade."[63]

TNI's research in early 2021 on drug use and trade in Rakhine (Arakan) State[64] found that the area had changed into an important transit hub for ATS. According to a Rakhine journalist from Maungdaw Township in northern Rakhine State:

> "Rakhine State is not a source of drug production, but it came to be the main route due to trans-boundary trade. The source of drug production is northern Shan State, and the routes to Rakhine State incudes both maritime and land ones. Just a small part of the drug trade ends up in Rakhine State, because the targeted areas are mostly Bangladesh and other Islamic and European countries. This is proven by the fact that the largest drug arrest cases in Rakhine State in 2020 are only found in Maungdaw, the border city of Rakhine State to Bangladesh. From there, it is so easy to trade to Bangladesh across the Naf River or via land connection in the northern part of the township"[65]

A Rohingya businessman from Maungdaw town explained how ATS was being trafficked through Rakhine State:

> "Yaba is usually carried in trucks or boats transporting goods, hidden inside the goods. These trucks carrying merchandises and yaba arrive directly from central or upper Myanmar to Maungdaw town. They deliver their yaba cargo sometimes outside of town in south Maungdaw, other times inside the town. The dealers in Maungdaw know where the yaba is hidden. They have legal businesses in the town, and use this as a cover to engage in drug smuggling." [66]

The 2021 research reveals that at that time different conflict actors and communities in Rakhine State were in one way or another involved in the ATS trade, a situation that still pertains. According to a Rakhine journalist from Maungdaw, several conflict actors were – at least indirectly – linked to the drug trade at that time:

> "The armed conflicts also have some relations with the drug issues. In some cases, Arakan Army (AA) supporters also do some kind of drug trading and so does the government military. In short, although these organizations may have no direct involvement, every group has indirect relations with the drug issue."[67]

A much smaller armed group, the Arakan Liberation Party (ALP), was also accused of involvement in the drugs trade. The ALP only has a very limited military presence in Rakhine State, but it has close relations with the Myanmar Army after signing the

Nationwide Ceasefire Agreement (NCA) in October 2015. According to one Rakhine researcher:

> "In particular, after the ALP signed the ceasefire in 2015, local sources claimed that it was allowed to pass freely through formal checkpoints, and that it used this privilege to engage in drug trafficking."[68]

The same researcher warned that:

> "It is difficult to completely deny its [AA] direct or indirect complicity in the drug trade, although the extent of its involvement remains unclear. Some argue that the AA merely taxes the trade without directly participating in it. At the same time, the Myanmar government's allegations against the group are largely politically motivated and aimed at undermining the AA both operationally and in terms of its legitimacy. In some cases, individuals associated with the ALP and the AA are confused by local people, and, of course, both groups blame each other."[69]

Since 2021, the conflict landscape in Rakhine State has significantly changed, with the ULA/AA gaining control of 14 of the 17 townships, while several small armed factions among the Rohingya population have become active on the Bangladesh border. The ULA/AA resumed its offensive against the Myanmar Armed Forces, and by December 2024 it gained de facto control along border territories with Bangladesh, meaning that cross-border trafficking routes passed through areas where it seeks to establish security and administration. ATS seizures data from the Bangladesh DNC show a significant decrease in 2024, most likely caused by the instability and disruption of the ATS trade as a result of the ULA/AA offensive. However, seizures reported by DNC in 2025 were back to the same levels as 2023.[70] According to a Rohingya businessmen involved in drug smuggling, interviewed in July 2026, the cross-border trade in yaba tablets had increased by "more than 100%" since the ULA/AA took control of the border.[71] Instabilities continue and monitoring remains difficult in an area where there are different conflict actors and border crossing points. But he also alleged that there are officials in the ULA Customs and Taxation Department imposing a fixed tax on the ATS trade.

To gain a full picture, therefore, it is essential but problematical to gain independent access to these front-lines. There are many elements to the ATS trade. Since the resumption of hostilities, the Myanmar military has imposed a total blockade on road and water transportation between central Myanmar and Rakhine State, and formal cross-border trade with Bangladesh was suspended. These restrictions remain in place as of 2026. In addition, the closure of the formal border trade with Rakhine State by Bangladesh has also made it increasingly difficult to conceal drugs among legitimate commercial goods. However, drugs continue to enter Bangladesh from Myanmar by sea, across the Naf River, and, to a lesser extent, through the land border. Smaller boats carry drugs across the Naf River and unload around Teknaf and Shapuri Dip. Small quantities are now smuggled across the land border, with consignments averaging up to 100,000 yaba tablets.

However, while trade restrictions on territory controlled by the ULA/AA are imposed by the Bangladesh and Myanmar authorities, maritime shipments of ATS have become the preferred method and generally involve much larger consignments, not only from Rakhine State but also from the Ayeyarwady Region and Yangon. Some smugglers deliver their cargo directly to major Bangladeshi ports such as Chittagong, and other ports along the coastal belt of the Bay of Bengal, but others tranship the drug consignments at sea.

Meanwhile, as elsewhere in the country, militia and crony interests linked to the Myanmar Army are still alleged to be deeply involved in the production and trafficking of heroin and ATS (see section on "drugs and conflict" in chapter 6). Myanmar Army members, for example, have been arrested in northern Rakhine State for drugs smuggling in areas that they then controlled."[72] Following its territorial expansion, the AA was also reported to have arrested 11 persons in Ponnagyun in 2025 for ATS trafficking,



ULA meeting releasing arrested drug users in Mrauk-U District, Rakhine State (APM)

including seven members of its own Department of Law Enforcement and Public Security (DLEPS). [73]

Against this backdrop, all sides in the conflict continue to accuse each other of involvement in the drug business.[74] According to the Rakhine researcher:

> "The drug trade is also a political issue. Both Bangladeshi and Myanmar authorities have presented what they describe as 'evidence', but there is still no tangible proof that the AA participates in or promotes the drug trade to finance its insurgency. From Dhaka's perspective, these allegations may also serve to increase political leverage over the ULA/AA in negotiations concerning security and the refugee issue. In many cases, reports from Dhaka appear to rely on cases initiated by Naypyidaw, which often involve 'Rakhine individuals, sometimes former AA members', arrested in Yangon or Mandalay for drug-related offences. AA officials typically dismiss these as fabricated or pre-arranged cases. On the Bangladeshi side, it is also worth noting that such large quantities of drugs could hardly have entered deep into Bangladesh without at least some level of complicity by border authorities, particularly the Border Guard Bangladesh (BGB)."[75]

Meanwhile, there have been examples of links between opposing sides in the lucrative drug business. According to a Rohingya social worker from southern Buthidaung:

> "Though Rakhine and Burmese people do not like the Rohingya people, they do get along in money matters. They know that Bangladesh is the only market to sell yaba to, and to sell large consignments in Bangladesh both the Arakan Army and Tatmadaw depend on Rohingya traders, who are well connected to Bangladeshi people and drug syndicates."[76]

While most of the ATS smuggled to Rakhine State ends up being exported to Bangladesh, ATS has also become cheaply and widely available in Rakhine State itself, igniting concerns about rising drug use, especially amongst youth. Prices have dropped from 1000 kyat (50 euro cents) per tablet to around

250 to 300 kyat in 2021.[77] This mirror trends seen elsewhere in Myanmar.

According to a Rohingya businessman from Maungdaw town, the number of small traders also increased following the 2021 military coup, with the drug price going down:

> "Not only the AA but also the Tatmadaw's agents are active in supplying drugs from upper Myanmar to northern Rakhine State. The Myanmar Army has their own way to bring yaba in northern Rakhine State and the AA also have their own people as well. No one is disturbing the other. As a result, yaba is available more than at any other times in Maungdaw. Buthidaung is also a good market place where 0.5 to 1 million tablets can be sold every day."[78]

In Bangladesh, meanwhile, Rohingya drug dealers have been receiving yaba consignments from Myanmar, first delivering them in refugee camps. At the time of the research in early 2021, many aspects of life in the large Kutupalong camp[79] and other refugee camps in the area were largely controlled by Arakan Rohingya Salvation Army (ARSA), ostensibly with support from the Bangladesh authorities [80]. ARSA is a Rohingya militant jihadist armed group that in 2017 attacked some 30 Myanmar security force outposts. The Tatmadaw responded with what it called a "regional clearance operation", mostly targeting civilians. As a result, over 700,000 Rohingyas fled to Bangladesh, where they joined a large pre-existing Rohingya refugee population who had fled earlier brutal campaigns of the Myanmar Army[81], bringing the total number to 1.2 million.[82]

These events, and the role of the Tatmadaw leadership, remain the subject of investigations by the International Criminal Court, International Court of Justice and other human rights bodies into war crimes and crimes against humanity. Beyond condemnation, however, little action has been taken, and humanitarian conditions remain grave, with the refugee camps also becoming another element in the drugs trade.

According to refugees interviewed for this report in early 2021, while ARSA officially



Balukhali Rohingya refugee camp in Cox Bazar, Bangladesh (KU)

banned drug trading and use inside the camps, such activities instead took place just outside the perimeter in local villages and nearby market places. At the same time, criminal gangs led by individual former ARSA leaders such as the "Munna Gang" – named after its leader Munna – established their drug businesses in various refugee camps. Rivalry between the Munna Gang and other ARSA members led to violent confrontations in Kutupalong camp in October 2020.[83]

Some ARSA commanders were also accused of involvement in drug smuggling from Maungdaw Township to the refugee camps in Bangladesh. According to the 2021 research, ARSA began recruiting refugees to undergo armed training in the hills of northern Maungdaw and afterwards trainees were ordered to carry drugs with them on their return to Bangladesh. A key Rohingya informant also commented: "Most ARSA commanders are now involved in the cross border yaba trade, because the armed group faces a financial crisis as 'donations' from the Middle-East and Malaysia have dried up."

Until 2021, the Bangladesh government denied acknowledging the presence of ARSA and other armed Rohingya groups in the refugee camps, despite persistent allegations of their activities. However, Bangladesh's position shifted following a series of violent incidents.[84] Collectively, these developments significantly reduced ARSA's dominance in the refugee camps. As ARSA's influence declined, the Arakan Rohingya Army (ARA), also known as the Nabi Hossain Group, emerged as the main Rohingya armed group involved in the drug trade.

Whereas Rohingya drug traders are primarily smuggling drug consignments across the border from Myanmar, local Bangladeshi dealers supply the wider Bangladesh market. They move the consignments to Cox's Bazar through local and refugee carriers. For short distances in Cox's Bazar District, they reportedly use rickshaw pullers, auto-rickshaw drivers and motorbike riders. Over long distances, drugs are transported via air travel, or carried by car, truck and motorbike, even ambulance.

For this reason, Bangladeshi officials and media have frequently accused Rohingya refugees of involvement in drug smuggling in the Chattogram-Cox's Bazar-Teknaf corridor. These claims, linking the Rohingya influx to crime and trafficking, have also shaped anti-Rohingya narratives over the years, a perception that is unfair and unhelpful to their cause. Tensions and accusations then escalated during the 2023-25 period when ARSA and other armed Rohingya factions joined on the Tatmadaw side in fighting against the AA.[85] Public opinion was also enflamed in Bangladesh after an intelligence officer was killed by ARSA members during an anti-smuggling operation.[86]

In the Myanmar context, such blame games are long familiar in the narcotics context. In the meantime, greatly less attention is paid to the socioeconomic desperation which often drives this activity, particularly among labourers, shopkeepers, taxi drivers, religious clerics, and youths who turn to peddling ATS as a means to support starving families. Until 2021, this shift was especially fueled by a lack of livelihood opportunities, movement restrictions and the effects of the Covid-19 crisis, all compounded by the absence of legal status that blocks access to employment and assistance.[87]

According to a Rohingya man from southern Buthidaung, the need to earn additional income also comes from arbitrary taxation imposed by different armed groups:

> "All these taxes deprive our families, and legal businesses are hardly enough to support them. So, the only option for us is to engage in the drug trade."[88]

In addition, the public debate often frames the Bangladesh-India-Myanmar border drug trade through a simplistic 'spillover' lens, casting war-torn Myanmar as the source of the problem. In this narrative, expanding trafficking is attributed to state collapse, porous borders, and the activities of armed groups alone. Rakhine and Rohingya organisations, and especially Rohingya refugees, are repeatedly accused of smuggling, often disproportionately so.[89] While some

armed groups and migrants are involved, these narratives deepen local grievances and obscure the fluid, adaptive nature of the borderland drug economy. Violence linked to competition in the drug trade frequently harms civilians, including inside Rohingya refugee camps in Cox's Bazar.[90] Reports also point to the involvement of officials from both Myanmar and Bangladesh.[91]

As concluded by a Bangladesh newspaper report, while Bangladesh' geographical location makes it "a hotbed for drug trafficking", current policies are partly to blame:

> "The problem perhaps lies in our approach to the issue, which on the surface seems to target the consignments, users and dealers. Where we fail is in going deeper to the roots and dismantling the system at the core. The system we are talking about is one that allows rampant corruption, nepotism, favouritism and self-interest to permeate every level of the state, from policymaking to enforcement."[92]

A Rakhine CSO activist from Sittwe paints a similar picture:

> "When I was jailed in Sittwe prison for political activism, I found some people jailed for the drug issues. But, as far as I knew, they are not the real people doing the drug traders. They are instead jailed for the real drug dealers who are very rich. "[93]

According to a Rakhine political analyst:

> "Sometimes, the authority only arrests the small drug dealers and not the big ones. I think it is due to corruption. For example, in a case in Maungdaw, drugs worth about 7,000 million kyats [350,000 euro] were seized. But the people they arrested are very poor, and it is sure that they do not own these drugs."[94]

In the meantime, the growing visibility of ATS in Bangladesh has fueled calls for harsher anti-narcotics operations by the government. A more repressive Narcotics Act was adopted in 2018, permitting the death penalty even for non-violent drug offences. Security forces routinely resort to extra-judicial executions in anti-drug operations, but claim that suspected drug dealers were killed in crossfire or gunfights. Despite intensified enforcement, the trade continues to flourish, with trafficking groups carving out alternative routes to evade authorities.[95]

Availability and affordability

At the regional level, prices of methamphetamine have continued to decrease significantly,[96] despite a sharp increase in police operations and reported drug seizures. This reinforces earlier arguments that drug policies in the region – primarily based on repression and drug-free objectives – are ineffective and unrealistic. Instead of escalating crackdowns, this trend should motivate governments to challenge the assumption that robust drug supply and demand control efforts can reduce availability and consumption. Public health, development and human rights-based approaches remain more promising alternatives, as further explained in the Discussion and Conclusion Chapter of this publication.

In Myanmar, the availability of methamphetamine and other synthetic drugs such as ketamine, MDMA, and "happy water" has increased since the Covid-19 pandemic and the 2021 coup. People can reportedly purchase drugs more easily at day clubs, KTV, roadside betel shops, as well as "old fashioned" dealers and friends. As a 28-year-old man from Hlaingthayar Township, Yangon, explained:

> "After the power shift, unemployment rose and many people turned to drugs to escape. Prices have dropped, making drugs accessible to almost everyone. Now people know exactly where to buy them – before they had to search for sellers."[97]

Amid conflict and the collapse of the rule of law, some respondents noticed declining enforcement, while others stressed that the risk of arrest remains high and depends heavily on the discretion of individual officers.



Chrystal methamphetamine ('ice')in Myanmar (DPAG)

Civil society actors also argue that the military regime deliberately makes drugs available to youth to deter political mobilisation and weaken the resistance of ethnic nationality communities against the junta.

Yet drug use is a complex social phenomenon shaped not only by supply but also personal, social and environmental factors. When asked why drug use was rising, a 20-year-old woman from Insein Township in Yangon replied:

> "When people are stressed, others suggest trying this or that. They see others using it and follow. Now even children aged 10 to 13 use these drugs."

In refugee and internally displaced people's (IDP) camps – for example along the Myanmar-Thailand and Myanmar-Bangladesh borders – illegal markets for synthetic drugs proliferate alongside other informal economies. Methamphetamine use has reportedly become more common amid precariousness and limited mobility.

For many young people, drug use becomes a diversion from daily life constrained by the lack of education, economic opportunities and freedom of movement.[98] Interviews also show that methamphetamine prices in Myanmar are generally lower than in other regional markets, reflecting the country's role as a major production hub. In China and Thailand, prices tend to be lower near the Myanmar border and rise with distance, underscoring how proximity shapes availability and affordability.

In Yangon retail prices for crystal methamphetamine also fell roughly threefold between 2018 and 2021, and the use has become more popular, especially among long-time tablet users. Comparable trends appear elsewhere in the region,[99] such as in Bangkok. As a 46-year-old man explained:

> "I use ice because it's cheaper and easier to find than heroin. If I have it, I use it several times a day. If I don't, I stop – there are no withdrawal symptoms like with heroin."[100]

Methamphetamine markets also showed no sign of slowing down during the Covid-19 crisis or after the 2021 coup in Myanmar. The 2025 UNODC annual report notes the highest methamphetamine seizures ever.[101] Examination of prices provides the clearest illustration of availability: in Yangon, methamphetamine tablets fell from 2,500-3,000 MMK (about 1 to 1.5 euro) per tablet before Covid-19 to 1000 MMK during Covid-19, and to around 500 MMK today. In Myeik, Tanintharyi Region, prices dropped from around 3,000 MMK to 800 MMK between 2017 and 2022.[102] In Hopin, Kachin State – a major drug-trade hub – prices plunged from 3,000-4,000 MMK per tablet in 2016-2019 to 1,500 MMK in 2023. While partly caused by inflation, such steep declines further show that supply-side interventions have not reduced availability.

In contrast, Covid-19 restrictions did heavily impact on drug availability in China. In 2021, users were forced to reduce their use or switch substances because prices rose sharply and purity declined. A 43-year-old man in Yunnan noted that heroin and xiaoma, costing 1,000 yuan per gram[103] (130 euro) and 50 yuan (6.50 euro) per tablet respectively, had become "hard to get recently."[104]



Smoking methamphetamine using water bottle as filter (TNI)

Poverty, marginalisation and involvement in drug markets

The single focus on supply reduction, seizures and eradication is not only ineffective but also unjust, especially when used to justify harsh laws and policing. Enforcement disproportionally targets small-scale couriers, informal workers and impoverished borderland residents, while powerful players with political protection remain largely untouched. This diverts attention from the structural conditions that allow drug economies to thrive. Most importantly, it distracts decision-makers from indicators that truly matter, particularly those related to ordinary people's access to health, education, welfare and safety.

Although methamphetamine has specific features driving its popularity in Southeast Asia, the expansion of synthetic drug markets is rooted in longstanding factors. Myanmar, the region's epicentre of ATS production, is marked by widespread poverty, food insecurity, land grabbing, environmental destruction, political marginalisation of ethnic minorities, systemic corruption, armed conflict, militarisation and limited access to essential services. These conditions form fertile ground for drug economies that enrich elites while exploiting the labour and precarity of the poor.

Such injustice is not unique to Myanmar. Across the region research shows strong links between economic precariousness, low-level involvement in drug markets, and punitive drug policy.[105] Gender inequality further deepens these harms, reflected in rising numbers of women imprisoned for low-level drug offenses.[106] This trend seems to continue, although to varying degrees. In 2025, Indonesia's National Narcotics Board (BNN) reported that 10% of those arrested in a major operation were women homemakers. As noted



UWSP raid on heroin and ATS factory in northern Wa region (TNI)

by the Institute for Criminal Justice Reform and LBH Masyarakat,[107] many women become couriers through coercion or manipulation by partners or networks. However:

> "The existing legal system tends to ignore the context of this vulnerability and punishes them in full, so that women face re-victimization from network exploitation and injustice in the judicial process. This punishment is always legitimized under the outdated jargon of the 'war on drugs'."[108]

Furthermore, the belief that "kingpins" drive the drug trade is misleading. The arrest of such individuals seldom disrupts operations, as others quickly replace them. In Myanmar, for example, the retreat of Khun Sa in the late 1990s had no long-lasting impact on production or trafficking, which continued through other actors.[109]

As this study shows, the drug trade operates as a fluid ecosystem dependent on numerous low- and mid-level participants who typically act independently of larger networks. Lacking alternatives, these individuals rarely understand the broader organisation of the trade. Interviews for this research highlight how poverty, food insecurity, exclusion and family problems push people toward low-level dealing. As a 38-year-old male taxi driver in Yangon explained:

> "My experience is that older people deal drugs because they have no family support and few job opportunities. Drug dealing is easy to earn money. Who would want to do this kind of job? But they have no other choice… Drug dealing cannot be controlled without solving the real social issues behind it."[110]

Other respondents emphasized corruption and collusion. A 28-year-old man from Hlaingthayar Township in Yangon noted that sellers "pay protection money to the police", which keeps them out of prison and maintains the market. He described a cycle of increased sellers, greater availability and rising use, facilitated by local officials working "hand in hand" with police and dealers.[111]

These examples illustrate the importance of how social and economic inequity – not greed – sustains the drug trade. Most cross-border couriers are impoverished

and vulnerable workers or ethnic minority residents supporting their families. Despite their minimal role and meagre earnings, they face the harshest penalties, including long prison terms or, in some countries, the death penalty.

Others sell drugs simply to cover their own or a partner's drug use:

> "Every day, with his drugs expenses on top of food, we are struggling. That's why I have to sell it to cover his expenses."[112]

Myanmar's political situation presently offers little hope for improvement. Five years after the 2021 coup, its devastating consequences are visible nationwide. Armed conflict has intensified across ethnic areas and spread into previously stable central regions among the Bamar-majority population. Indiscriminate violence – air strikes on civilian targets, torture, arbitrary arrest, sexual violence and extrajudicial killings – has reached unprecedented levels. Combined with the impact of Covid-19, the coup has plunged the country into a severe economic crisis, threatening livelihoods in urban and rural areas alike. As food insecurity grows, the number of people living in precarious conditions continues to rise. Migration, whether to mining areas such as Hpakant or abroad, has thus become a key coping strategy, one that is increasingly fraught with risks, including irregular status, the tightening of restrictions and a heightened risk of exploitation and abuse by employers, criminal actors and authorities, all of which deepen vulnerability.

Methamphetamine use in different contexts

Large numbers of people use methamphetamine tablets to cope with exhausting manual labour and long or irregular working hours. Such occupational use is common in jade mining in Kachin State, the fishery sector in Myanmar and Thailand, among taxi and highway night drivers, and on construction sites. These workers often rely on stimulants to enhance productivity and income, despite health risks linked to regular use and poor living conditions. As a male office worker in Thailand noted, some use methamphetamine to "increase work effectiveness", even injecting before work when exhausted.[113] A male harm reduction worker in Bangkok confirmed yaba's popularity: "Its stimulant effect makes users feel energetic… Most take it orally since no equipment is required."[114]

Similar patterns appear in rural communities, including in fishing villages in Mon State in Myanmar, where workers use two to three pills to "stay awake, keep eyes open and for good tenacity."[115]

A 2023 study on urban informal workers in Thailand found that food delivery and service workers reported the highest levels and widest range of drug use, including crystal methamphetamine, methamphetamine pills and ketamine. Drug use often began early in people's lives, with many participants using substances from the age of 15. The study also showed that nearly 80% have no education beyond junior high school, suggesting early life stress and precariousness. Many respondents attributed their drug use to harsh working conditions, including the absence of labour protections, lack of contracts, and long, unstable hours. Importantly, the study also revealed that workers use a broad spectrum of substances – both legal and illegal – ranging from energy drinks, alcohol, sleeping pills, kratom and codeine cough syrup to stimulants like methamphetamine.[116]

Comparable findings emerged in Indonesia, where working-class groups – including sex workers, security guards, domestic workers and hospitality staff – living in low-income areas use methamphetamine to gain energy for work, manage stress or to fit in with peers and co-workers.[117] According to villagers in Indawgyi Township, Kachin State, some gold miners – who also face challenging labour conditions – receive drugs (such as opium, heroin and methamphetamine) as payment and become dependent as a result.[118] This reflects the complex relationship between labour and drug use: stimulants help workers endure the physical and psychological toll of

exploitation and precariousness but at the same time it is adding to their vulnerability.

Methamphetamine use also intersects with sex and entertainment work, where stimulants help manage demanding schedules or client pressure.[119] Youth use further illustrates generational shifts. A man from the town of Myeik in southern Myanmar noted that: "WY and ICE are common among young labourers, starting from ages 13 or 14… especially in neighbourhoods where workers live in close quarters."[120]

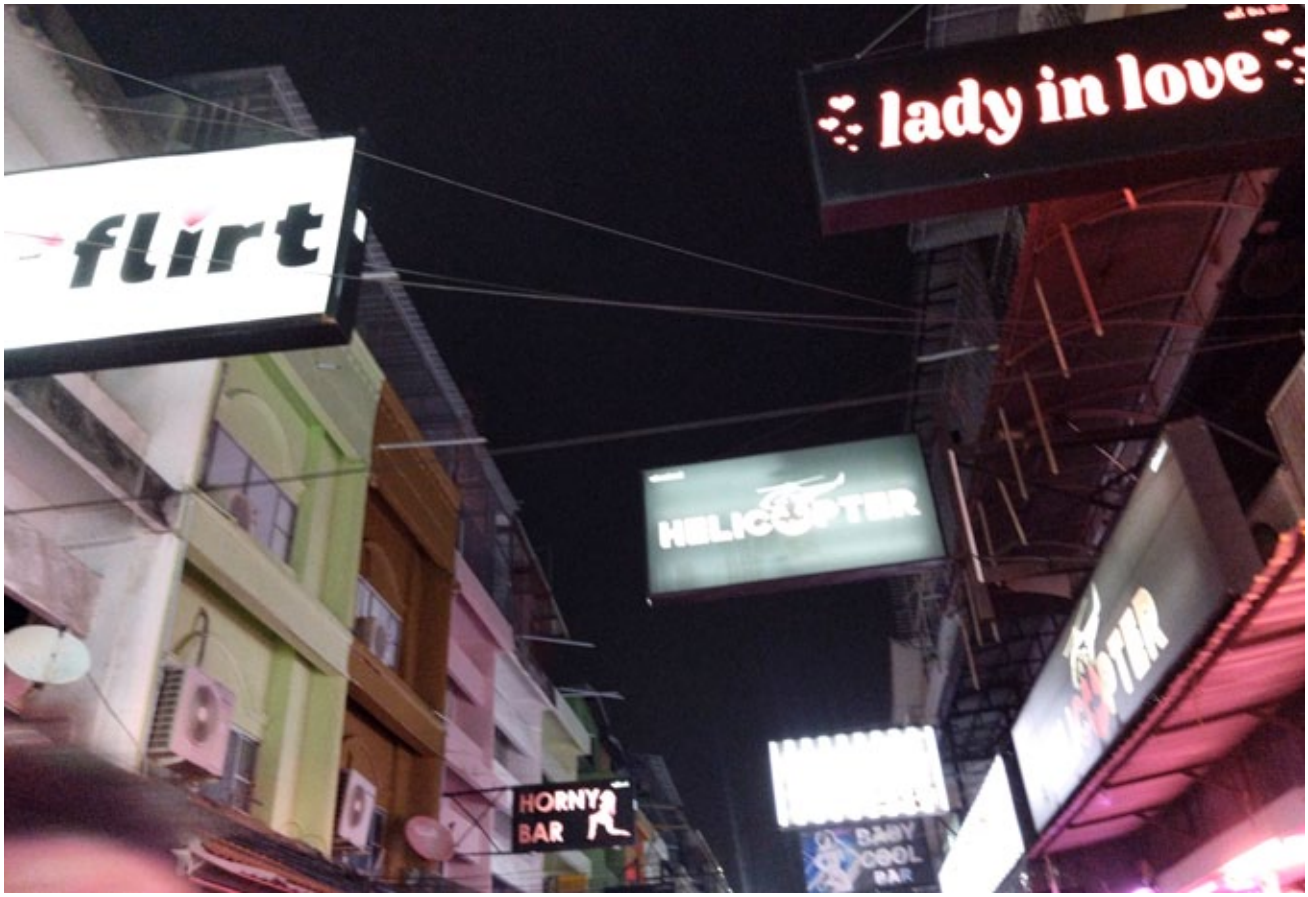
The post-coup boom in entertainment venues – KTVs,[121] casinos or nightclubs – is another trend commonly associated with methamphetamine and other synthetic drug use. A man in Kachin State described new clubs where "alcohol is substituted with drugs: K [ketamine], E [ecstasy], Collagen, Shwe [happy water], and Ice."[122] In Hpakant, stimulants are widely consumed in nightlife settings, with yaba sold for as little as 500 MMK (25 euro cent) per pill.[123]

Drug use is also prevalent among soldiers in the Myanmar Army, who take stimulants to endure physical activities. One soldier said drugs allowed troops to function despite hunger and exhaustion, although withdrawal during operations caused severe fatigue.[124]

Crystal methamphetamine is typically high in purity, whereas tablets often contain only low levels of methamphetamine mixed with caffeine.[125] Youths are among the primary tablet consumers, using it socially with friends, often recreationally rather than daily. While many do not develop harmful patterns, risks remain high due to limited harm reduction education, poor access to health services, stigma, and broader psychosocial stressors at home, work and within communities.[126]

Gender, age and stigma

Methamphetamine tablet use appears to be increasing among young women across all countries in this study. Some are drawn to its sweet, chocolate-like smell and its uplifting, confidence-boosting effects. For others, use is tied to body image pressures or the need to remain productive in both paid and unpaid



A street in Pattaya, Thailand (TNI)

work. As one woman in Yangon explained, she uses methamphetamine "to focus on doing household chores such as cooking and cleaning."[127] Meanwhile, a 2023 study of urban informal workers in Thailand found that young women reported using ecstasy and ketamine because they believed these drugs offered "dietary advantage", improved job opportunities, and enhanced "sexual attractions and beauty privilege".[128]

Women also differentiate between substances in terms of desired or feared effects. A young woman in Yangon described why she preferred methamphetamine tablets over crystal methamphetamine or heroin:

> "My parents were strict... After I use the methamphetamines pill my mind is free and I become happier... But heroin is different, when I use it, I don't think about anything and the feeling is so high. I also used ice and it made me feel frightened... I didn't trust anyone and thought they were all police watching me."[129]

These accounts highlight that women's ATS use is shaped not only by recreation, but also by gendered expectations, beauty norms, workplace pressures, and household responsibilities.



WY methamphetamine pills in Yangon (DPAG)

Although methamphetamine use carries less stigma than heroin – partly due to "public health campaigns that focus on heroin"[130] – stigma remains a major barrier to seeking support. Many people avoid services for fear of being exposed. As a young woman in Thailand explains:

> "I don't want anyone to know I am a drug user... I am very concerned about my privacy and want to keep my secret from my parents."[131]

Users also describe being labelled as "thieves" or "dangerous". A woman from Yangon notes:

> "People think drug users are bad... The sins of bad guys and thieves should not be placed on drug users."[132]

Stigma is also gendered and harsher for women. A 45-year-old woman, who also works as a dealer in the town of Pyay in central Myanmar, observes:

> "For women, it's even worse. Men get some leniency, but for girls it's much harsher... They might face punishment for simply speaking out."

Some women begin using through male partners, who may pressure or introduce them to use. A woman in Yangon recalls:

> "When he inhales the methamphetamine pill, I also inhale the leftovers and I like it."[133]

Another woman notes reliance on male family members for sourcing drugs. Yet drug use among women is not always tied to partners.[134] A 48-year-old sex worker in Yangon emphasizes both autonomy and stigma:

> "If people see me smoking or drinking, they would view me as a 'bitch'... When they know I sometimes use WY, they avoid me like an infectious plague."

Stigma also affects young people's access to education. In parts of Myanmar, students caught using drugs can be expelled from



ATS pills and heroin in northern Myanmar (TNI)

school, a punishment which can have damaging consequences for their careers and lives. This has led some local authorities, such as the New Mon State Party (NMSP), to change this practice.[135]

Levels of "acceptance" may therefore vary by substance and social group. Among casual workers, methamphetamine may be tolerated as long as it enhances work performance. Wealthier people may view ATS as a recreational or "party" drug. However, heroin use remains more heavily stigmatized. A man from Yangon explains:

> "My friends at school don't like using heroin and don't accept I'm using it. When I got addicted to heroin, I stopped hanging out with them... In the past, heroin users were discriminated against as if they were all infected with HIV."[136]

Perceptions of health and other risks from ATS use

Many people who use ATS do so without experiencing serious problems.[137] The European Union Drug Agency defines problematic drug consumption as a recurrent drug use causing harms such as dependence or social, psychological and health problems.[138]

Globally, while nearly 300 million people use illicit drugs, only about 40 million have a drug-use disorder, meaning most users do not develop dependence or other related problems.[139] A WHO study notes that perceptions of ATS risks tend to swing between extremes: some governments treat any use as dangerous and criminal. Elsewhere, notions prevail that recreational use causes no long-lasting harms, and it is likely to be simply discontinued by the users of their own accord without the need for outside interventions. According to the WHO, the truth lies somewhere in the middle.[140]

Research in Australia suggests only around 3% of methamphetamine users are regular users,[141] while another study estimates that around 11% meet criteria for dependence.[142] Still, as noted in an earlier TNI publication, even occasional users may face physical, social or psychological harms, and some may escalate to more intensive patterns.[143]

Young people interviewed for this study often described methamphetamine as a social drug that is easier to conceal and control than heroin, in part due to the absence of intense withdrawal symptoms. A person in Yunnan stated that "even after 3-4 days without xiaoma the withdrawal symptoms aren't obvious."[144]

Research in Indonesia and China show that many people perceive methamphetamine as non-addictive because they can regulate consumption,[145] and that the greatest perceived risk is arrest rather than health problems.[146] Yet reduced withdrawal does not mean no harm. A former user in Kyaikmayaw Township in Myanmar's Mon State described how methamphetamine initially boosted creativity and confidence but ultimately eroded his health, appetite, relationships and daily functioning.[147]

Some risks are linked to lifestyle and living conditions – poor hygiene, irregular sleep and eating patterns, and challenging social environments. Polydrug use adds further concern, especially for people who combine heroin and ATS to balance effects, heightening overdose risks.[148] A 27-year-old woman in Yangon recounted being advised to use opium, and later heroin, to sleep well and gain weight after becoming dependent on methamphetamine, thereby increasing potential harm:

> "After I became addicted to methamphetamine pills, the dealer gave us some ice to taste. Then we preferred ice more and the dealer sold it to us. When I used ice, I did not sleep at all, I became thinner and did not want to eat. The dealer suggested that if I use opium with tea, I will be able to sleep. My husband also suggested to me to use heroin, and then I started using heroin and my limit became higher."[149]

In addition, there is growing evidence of links between ATS use and HIV transmission, which in the past was mainly seen as a problem affecting injecting heroin users. A 2012 Malaysian study among opiate users who also used ATS found that:

> "ATS use spread rapidly in the study sample after 1997 and is associated with an increased risk of HIV infection in this population already at high risk because of opiate injecting drug users (IDUs). Out-of-treatment IDUs in Malaysia engage

Figure 4: Drugs ordered by their overall harm[150]

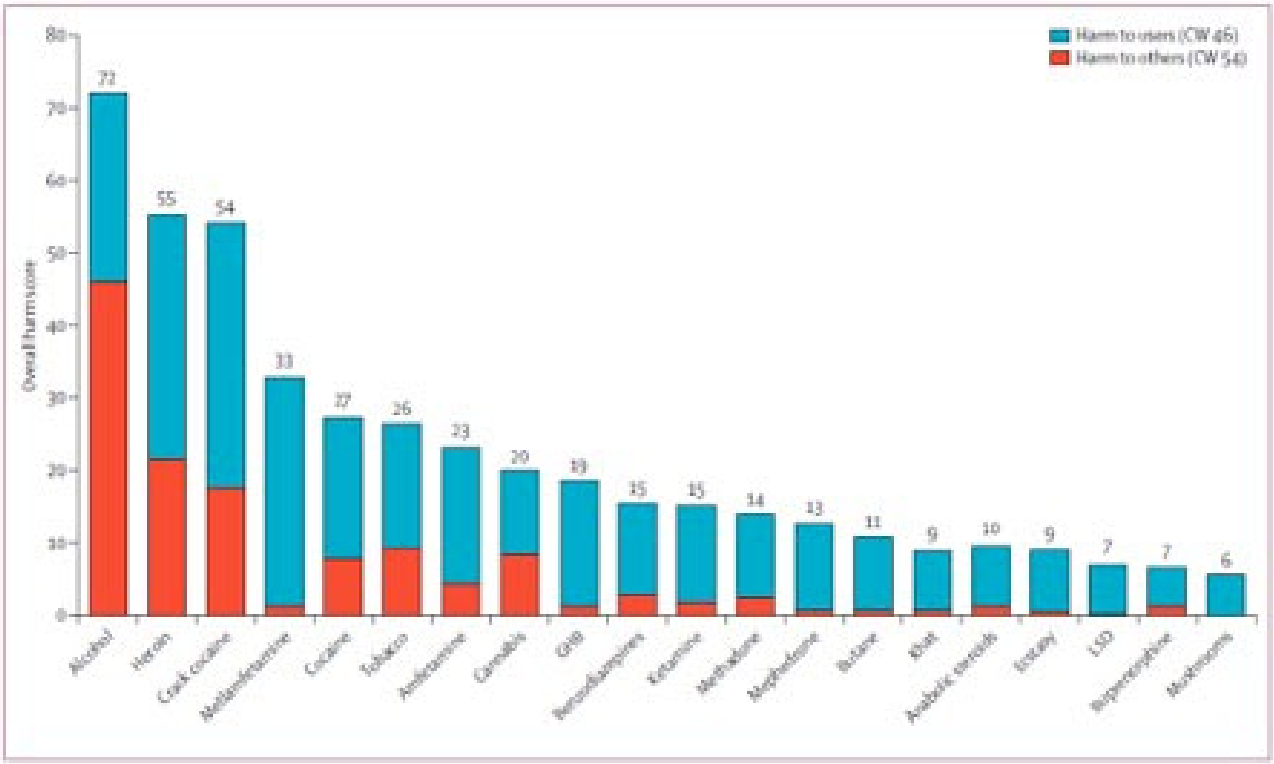


Figure 2: Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others. The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

Source: Nutt D J, King L A, Phillips L D (2010), "Drug harms in the UK: a multicriteria decision analysis", on behalf of the Independent Scientific Committee on Drugs

in high risk behaviors regardless of their HIV status. Increased education and public health prevention measures are needed to reduce HIV transmission risks in this population.

Although the results from this cross-sectional study should not be interpreted as proving a causal relationship between ATS use and HIV infections… ATS use might contribute to increased HIV infection by a number of behavioural and biological pathways such as, including increased energy and interest in heightened sexual activities; impaired judgment, leading to increased frequency of unsafe sexual practices; increased frequency of IDU or equipment needle sharing; or more impulsive sharing in particularly high risk situations injecting."[151]

Research among men who have sex with men (MSM) likewise shows:

"Methamphetamine use clearly affects both physiological and psychological aspects of sexual behaviour and may facilitate risky sexual practices, including unprotected sex, thereby increasing the risk of HIV transmission… HIV prevention programmes targeting MSM should consider including interventions designed to address meth/amphetamine use."[152]

The WHO also recognizes the link between ATS use and HIV and other communicable diseases. According to a WHO study on ATS:

"The growing use of ATS is associated with the spread of HIV and hepatitis in diverse segments of the population, largely due to an increase in risk-taking behaviour and unsafe sex practices among users. The rising trend in injecting use of ATS is a further cause for concern."[153]

Comparative risk assessments reinforce that ATS-related harms vary. A 2009 Dutch evaluation of 17 substances ranked amphetamine and methamphetamine in the mid-range for dependence potential and social harms – far below heroin, crack and alcohol, but above drugs like LSD or ecstasy. The study noted that 12% of the methamphetamine users in The Netherlands reported involvement in violent crime in the past year.[154] A similar UK assessment in 2010 produced comparable findings about harmfulness.[155] Overall, while ATS use does not necessarily lead to severe harm for most users, contextual factors – including polydrug use, socioeconomic stress and lack of harm reduction services – can significantly heighten risks.

Self-regulation and harm reduction

The way a substance is administered strongly shapes its effects and risks. In Southeast Asia, methamphetamine can be swallowed in tablet form or more frequently smoked through improvised pipes, though "ice" has contributed to rising injection use. Injecting significantly increases harms, including musculoskeletal and vascular damage,[156] blood-borne infections from shared equipment, and heightened risks in sexual contexts. Some users inject multiple times a day, and sometimes inject stimulants into the genitals.

A man in Myeik in southern Myanmar described local patterns:

"WY and ice are more commonly used in less crowded places due to the smell… Weed is mixed with cigarettes to mask odour… K [Ketamine] is snorted from a flat surface, while E is swallowed or mixed in soft drinks or alcohol."[157]

Recognising the risks of methamphetamine use is therefore essential for effective harm reduction approaches. Basic practices – avoiding binges, taking breaks, eating and sleeping adequately, maintaining hygiene and not sharing filters – can mitigate many harms. Research into self-regulation also highlights how users consciously moderate their consumption. Outreach initiatives in some countries provide information, online resources and safer-use materials,[158] although such services remain extremely limited across Southeast Asia. In practice, people

Testimonials on buying and selling in Thailand and Myanmar

"Buying drugs is relatively easy, and people use their own contacts and connections. Some buy directly, others rely on friends and give them a share. K and E can be found in KTVs, and weed is also easy to purchase."[159]

"I think because new places like 'day clubs' are popular among young people, it has become very easy to buy drugs. When friends say, 'Why don't you try this?' people listen and start using. Before, even sitting in a beer pub was difficult, but now it's normal. After the military coup there were fewer arrests, and drug prices fell sharply."[160]

"It has become much easier to obtain drugs. You can buy a pill for just 2,000 kyats [50 euro cents]. You simply park your motorcycle in front of a house and sellers give you however many you want. Prices dropped to 700-800 kyats, so even people collecting trash or beggars can buy and use... In the past [2019], profits were high. After selling a whole pack, you could make 400,000 to 600,000 kyats [170 to 260 euro], enough to spend freely at bars or KTVs and still have cash left.[161]

"I can buy Ya-Ba at 50 Baht [1.4 euro] per pill but, if I order a pack of 200 pills, I pay only 6,000 Baht [165 euro]. Back in 2003 during Thaksin's government when the government waged the drug war, yaba was very expensive. The price was at 200 Baht [5 euro] a pill. People smoke it; others inject it. I think the strength of yaba today is lower because it's produced in high amounts."[162]

"I think the most popular drug is Ice which I could buy at THB 500-800 [14 to 22 euro] per gram from a close friend. The market price of Ice is around THB 1,000-1,500 per gram [27 to 41 euro]. I used to buy at least 5-10 grams. [That way] I could get it at the lower [wholesale] price, and reduce the risk of being spotted and reported to the police."[163]

who use drugs often rely on their own or the experience of their peers.[164]

Some users also turn to plant-based substitutes. In Mon State, in particular, kratom has partially replaced methamphetamine for some peoples,[165] while others use cannabis to regulate stimulant intake.[166]

A 2019 TNI study found access to evidence-based harm reduction and treatment for ATS use severely lacking.[167] Valuable models, however, still exist. In Jakarta, a local harm reduction organisation Karisma conducted outreach to offer information on methamphetamine, mental health and safer smoking kits.[168] Participants valued both the materials and the sense of being heard. As the TNI study noted, most people have developed ways to regulate their methamphetamine use, mainly acquired through direct experience.[169] Peer-to-peer learning remains crucial. A male user in Bangkok remarked:

> "Knowledge of drugs and how to reduce the risk can't be found in mainstream media; it mostly comes from the experiences of friends."[170]

A young man in Yangon described how practices evolve:

> "We used only pipes and tin foil... Now we place a cap between the straw and mouth, or use homemade devices with water

> filtration. We believe this protects our teeth and gums."[171]

In Vietnam, the Centre for Supporting Community Development Initiatives' (SCDI) 2018-2020 programme trained 41 outreach workers to provide harm reduction, mental health support, and referrals. Despite Covid-19 disruptions, the programme reached over 300 clients, many of whom reduced use and gained access to psychosocial care. Participants particularly valued non-judgmental support amid persistent stigma.[172]

Drug checking is another harm reduction method, though formal services are absent in Southeast Asia. Some users have improvised their own testing: "I use Haiter bleach [a liquid for bleaching fabrics] – if the ice evaporates completely, it's good; if not, it leaves stains and turns yellow."[173]

Users also report that online information has improved their ability to regulate use:

> "Side effects and usage information are easily available online.... So people can use more consciously."[174]

Some users note that the fumes of crystal methamphetamine are less pungent than those of methamphetamine tablets. Others describe how adding ice to tablets prolongs burning and produces stronger initial effect. Ice also has greater potential for injection, which carries increased risks for health. These include the transmission of HIV, hepatitis C or other infections through the use of non-sterile injecting equipment and the sharing of injecting equipment, as well as higher risks of dependence. Although less common than smoking, injecting is more prevalent in certain settings. In Bangkok's LGBTQ+ community, injecting ice in sexual contexts ("slamming") aims to create emotional connection and intensify sexual experiences.[175]

In consequence, slamming is associated with elevated risks, such as sharing injection equipment and engaging in unprotected sex, and it is often stigmatized – including by health providers. Better understanding, decriminalization and destigmatisation are essential. Community members must be empowered to craft their own harm reduction strategies. At minimum, services should include HIV and STI prevention, comprehensive sexual education, psychosocial support, and voluntary, evidence-based treatment for those who need it.[176]

Harm reduction and treatment interventions must be tailored to the specific needs of stimulant users, who often do not identify with opiate-focused services and thus avoid centres that serve both groups. Effective interventions need culturally specific, targeted messaging and should empower peer networks. For people who inject stimulants, access to sterile needles and safer-injecting, information is essential, given the frequency of injecting and the risk of sharing of injecting equipment. For those who smoke, promoting safer techniques – such as using appropriate pipes and filters – can reduce harm as smoking remains less risky than injecting. Consistent condom and lubricant use should also be encouraged to reduce sexually transmitted infections risks linked to stimulant use and sexualised drug use.



Methemphetamine pills sold in plastic straw wraps in Yangon (DPAG)

Chemsex experiences

Chemsex refers to the intentional use of psychoactive drugs before or during sex to enhance pleasure, prolong stamina and lower inhibitions. Though anyone can engage in this practice, it is most commonly associated with men who have sex with men (MSM) in parties, gatherings or sex work settings, often connecting through dating apps and online platforms. A 2021 APCOM scoping review across Bangladesh, Hong Kong, Malaysia, Singapore, Thailand, the Philippines and Vietnam shows that crystal methamphetamine (ice), ketamine, gamma-hydroxybutyrate (GHB) and poppers are the substances most frequently used.[177]

Some distinguish chemsex from the broader concept of sexualised drug use (SDU). Chemsex typically involves longer, more ritualised sessions aimed at enhancing sexual experience, whereas SDU can occur in a wider range of settings – sexual or romantic relationships, social gatherings, clubs, brothels – and may be driven by pleasure, bonding or coping. Both practices carry significant risks, including HIV and STI transmission, dependence, mental health harms and, sometimes, potential coercion.

Respondents in Thailand shared their Chemsex experiences:

> "Right now, I mainly use it for sexual activities like group sex, two or three times a month. I went to rehab once and stopped for four months, but when I came back to Bangkok and saw the same group of friends I started to use again."[178]

> "The popular drugs now are ice due to easy accessibility, cheaper prices and fast delivery. They are delivered to your home, and you can find information online... In MSM groups ice is often used. Equipment can be easily purchased for smoking, intravenous injection or rectal injection. If smoked, it is used for hangouts; if injected, it acts immediately to stimulate arousal."[179]

> "Compared to 10-15 years ago when LGBT acceptance was limited, drug use was also hidden. But now, as many more people are 'coming out', we observe more people using drugs. We see many Twitter, Facebook and Instagram profiles in Thailand clearly describing themselves as drug users.[180]"

> "In the LGBTQ+ community, there is more use of crystal methamphetamine or 'Ice'. Some believe it increases sexual pleasure, extends intercourse and makes you horny."[181]

> "I was 40 when I tried slamming meth by intravenous injection after a client invited me during a massage. I believe I can control my use: I only use it when providing a massage with sexual services. The drugs depend on the client, who also brings them. I prepare the equipment for smoking or injecting. I use only 10 units of crystal meth each time; the client operates the injection. I use it about twice a month, depending on the client, and we negotiate use beforehand."[182]

Other synthetic substances

In addition to methamphetamine, a growing range of other synthetic substances is used across Southeast Asia, including ketamine (K or ya-K), MDMA/ecstasy (E or ya-E), poppers and "happy water". Their use is tied with nightlife and entertainment venues. Although less widespread than methamphetamine, these substances appear to be gaining popularity among young and urban populations. Supply was briefly disrupted during the Covid-19 pandemic, with locals reporting higher prices and reduced purity, but availability and potency rebounded once restrictions eased.

A 26-year-old male user from Bangkok explained in 2021:

> "Young people think ketamine is cool in their friend's eyes... Today ya-K comes in crystal form, like ice, and needs to be ground before snorting. In the past, it came as a liquid and had to be microwaved to dry. The second most popular drug is ya-E [MDMA], usually taken orally or chewed with gum. The user feels energetic and has more fun. The price is at 350 Thai Bath [about 9 euro] per pill."

A 19-year-old woman from Thailand described her early use:

> "When I was 15 years, I tried ketamine for the first time. My friends were using it and having fun, so I wanted to try. I felt so good... I used it two to three times a week, sometimes four times a day. Whenever the effect wore off, I used again. I used it for a year."[183]

Poppers (alkyl nitrites[184]) are also frequently used in sexual settings. A 37-year-old man from Bangkok noted:

> "Poppers are bought in bottles with many scents. You sniff it; it helps reduce pain during sex and increases pleasure. The effect is short, so you need to use it often. In LGBT groups people don't usually use just one drug – often a popper with ice, and if the penis is not erect, they add viagra."[185]



Ingredients to make happy water in Myanmar (DPAG)

A more recent substance on markets in Myanmar and Thailand is 'happy water', increasingly popular among club-goers. Prices are high: in Yangon a sachet (6-10 doses) costs 300,000 – 500,000 MMK (65 – 110 euro). Usually sold as a powder, it contains varying combinations of ketamine, methamphetamine, MDMA, diazepam and caffeine.[186] It can be mixed in drinks, though its shifting composition has been linked to overdoses, prompting government warnings.

Despite its reputation as "new", the term 'happy water' (and 'fairy water') appeared as early as 2009 in a presentation by China's National Narcotics Control Commission.[187] Later, the 'Shine Bee' drink, as it was known there locally, was banned in 2017 when found to contain GHB.[188]

A user from Yangon described its effects:

> "It gives a high, makes you want to dance... People usually party all night. In high-end clubs, cocaine and ketamine are also available. After effects include lack of sleep, loss of appetite and a depressive mood. If you don't stay awake and

dance after taking it, you might become unconscious and have an overdose."[189]

Non-medical use of pharmaceutical – benzodiazepines, codeine cough syrups, diazepam and painkillers such as tramadol – also persists. These substances are used to self-medicate, offset stimulant effects or manage stress. In Karen refugee camps in Thailand, community workers report that some youth like to mix tramadol with cough syrup for relaxing, and relief stress and depression.[190] Some other users encounter them through circumstance, as a respondent from Myanmar recalling his time in the military:

> "When I first started using drugs, it was diazepam... In 2005, you couldn't buy it in a regular drug store without a prescription. But since we were military, we could buy it openly with the signature of my friend's father, a medical assistant. We'd get cartons of diazepam."[191]

In Malaysia, nimetazepam (Erimin) has been used as a heroin substitute or to ease the methamphetamine come-down.[192] In Indonesia's 2021 national survey, after cannabis and amphetamine-type stimulants, the next most-used substances were dextromethorphan (a common cough suppressant) and benzodiazepines, such as nipam, lexotan, rohypnol, mogadon, and valium,[193] used for sedative or dissociative effects and sometimes to complement and/or substitute other drugs.

In Manipur, India, young people reportedly consume a wide range of pharmaceuticals. Reported drugs include alprazolam (Benzodiazepines) and dytor tablets (diuretics), cyclopam syrup (a paediatric drug for the stomach), phensdyl syrup (cough syrup containing codeine), and sinarest tablets (treatment for colds and flu) for their psychoactive effects. These products are manufactured in mainland India, a large producer of pharmaceutical products, and sold locally over-the-counter. For this reason, locals suggested that the poor quality of illicit drugs and easy pharmacy access are contributing factors to the popularity of drugs used.

In consequence, no severe harms were reported, but further research is needed. Importantly, substances such as ketamine, morphine and benzodiazepines are part of the WHO "essential medicines" list. Efforts to limit non-medical use should therefore not undermine legitimate medical access.[194]



Preparing happy water in Myanmar (DPAG)

Impact of drug policies on individuals and communities

The growing popularity of methamphetamine and other synthetic drugs in Southeast Asia has largely been met with harsh prohibition policies. Across the region, approaches have produced widespread human rights violations, affecting not only people who use drugs and those involved in the market but also their families and communities. Repressive strategies have led to mass incarceration, capital punishment, and extrajudicial killings, resulting in people losing their right to health, livelihood, fair trial and in some cases even life.[195]

Experience of a 32-year-old man who uses drugs in Thailand

"I have not been convicted or imprisoned for possessing drugs, but I was forced to take roadside urine tests three times while riding my motorcycle, despite wearing a helmet and having a valid license. The police set up illegal checkpoints with no senior officers present and no proper place to collect samples. They hid behind pillars of an elevated train station under construction and suddenly they jumped into the road. I had to brake abruptly to avoid hitting them.

My test came back positive for methamphetamine. I didn't argue and paid a bribe. The first time they demanded 50,000 Baht [1,350 euro], but I showed them I only had 20,000 Baht [540 euro].

The second incident, in 2018 in the very same spot, cost me around 20,000 Baht. My transgender friend on the back of my bike had to pay 30,000 Baht.

The third time, in early 2020, I had only 5,000 Baht. I gave them misleading information about the dealer I bought from, but two officers insisted the money was for their boss. One officer then demanded something else; he sexually abused me from 8pm to 8am the next day. All of this happened solely based on urine tests; they never found drugs in my possession.

Some people are less "lucky". If drugs are actually found, users are arrested and jailed, especially those who cannot afford to bribe the officers. Dealers, however, often escape serious consequences because they have connections with high-ranking police."[196]

Criminalisation of drug use and possession for personal use has resulted in mass incarceration. In Thailand an estimated 73% of around 270,000 incarcerated people in the country are detained for drug-related offences. While slightly lower than in Thailand, by 2024 drug-related offences still account for a large share of prison populations across Southeast Asia – around 51% in Indonesia, 53% in the Philippines, and over 60% in Malaysia and Singapore. Pre-trial detention remains common, often coupled with limited access to abuse, healthcare and legal aid.[197]

Drug users from Thailand highlighted the widespread use of urinal drug testing, which, if found positive, can lead to forced detention or short-term imprisonment. Explained one male user in Bangkok:

> "If the local police remember your face and know you use drugs, they will force you to take a urine test. If it's positive, they send you to forced rehabilitation or imprison you for 45 days. In prison it was extremely difficult. I was in pain from withdrawal symptoms and no one cared unless you were near going into a coma. Only then they moved you to the nursery ward. No methadone is provided to heroin users, so we suffer from withdrawal. I was arrested twice, and both times the quality of life were really bad. We were taken to a military camp for 'rehabilitation' – not a real programme. Officers made us exercise, run endlessly, sweep the field, and our freedom was completely restricted."[198]

Diversifying strategies for diversifying drug markets

Recent developments around methamphetamine and other synthetic drugs show how underlying factors – armed conflict, socioeconomic inequality, entrenched political crisis – directly shape the drug trade.

The Thai Narcotics Code and the resurgence of prohibitionism

The amended Thai Narcotics Code, long announced since the 2016 United Nations General Assembly Special Session (UNGASS) on drugs, finally came into force in December 2021 and consolidated 24 separate drug laws or texts into a single framework. After this UNGASS, Thai authorities held multiple consultations to ensure the new law aligned with international conventions and reflected human rights language found in the UNGASS Outcome Document,[199] particularly around compulsory treatment, criminalisation, alternatives to incarceration, and the proportionality of sentencing. According to Thailand's statement at the CND in 2021, the aim was to shift towards a more health-based approach by promoting voluntary and community-based treatment and reducing penalties.[200]

The new Code does introduce some important improvements. Cannabis (except extracts over 0.2% THC) and kratom were removed from the controlled list, and the law reduces penalties for minor trafficking,[201] abolishes mandatory minimum sentences for lower-level offences, and distinguishes more clearly between small and large traders. The Code allows for harsher punishments for masterminds and financiers and regards drug users as patients that need treatment rather than punishment.[202] Judges also have greater discretion to consider a defendant's role and socio-economic background. Officials suggested that these changes could reduce the prison population by about 20,000 people,[203] which is modest relative to the scale of incarceration.[204]

On the other hand the code continues to authorise urine drug testing, a provision that has been reinforced by political directives such as Prime Minister Srettha Thavisin's 2024 call to test "high-risk groups aged 16 and above".[205] According to civil society advocates, the code enables police to set up roadside checkpoints and conduct mass urine testing under the justification of public safety.[206] In practice, these tests have frequently led to extortion or, for those unable to pay bribes, imprisonment or compulsory treatment.[207] Similar patterns have been reported in rural areas and refugee camps, where positive tests may result in fines, eviction or additional punishment.[208]

Although the Code refers to voluntary rather than mandatory treatment, people suspected of drug use must agree to "voluntary treatment" or face imprisonment and fines,[209] effectively preserving coercive approaches. Harm reduction is mentioned but its scope remains unclear, pending future by-laws, and risks being conditional on failed treatment attempts.[210] Meanwhile, authorities have repeatedly altered the possession threshold for methamphetamine: from 15 pills in 2022, to one in 2023, then to five,[211] and finally back to only one in 2024.[212] These oscillations underline the continued dominance of a prohibitionist mindset despite rhetorical commitments to health-based reform.

Rather than signalling a major shift, these changes are a reflection of the capacity of drug markets to adapt to new circumstances.

Without long-term plans to address these structural issues, supply- and demand-reduction efforts will continue to fail. Repressive policies based on criminalising low-level drug offences disproportionally harm the most vulnerable and perpetuate exclusion and discrimination. Despite growing evidence, policymakers often ignore the public health benefits of harm reduction and decriminalisation. Punishment for use and possession prevails, and when treatment or rehabilitation is offered, it is frequently coercive. In 2012, 12 UN agencies issued a joint statement which warned against the

severe negative impacts of compulsory drug detention, and called upon countries "to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community."[213] The statement further states:

"In recent years, the numbers of such centers and of the people confined in them have been on the rise. In Asia alone, it is estimated that some 300 000 people are kept in compulsory drug detention and rehabilitation centers. People who use or are suspected of using drugs, people who have engaged in sex work and children who have been victims of sexual exploitation are detained without due process in the name of 'treatment' or 'rehabilitation'.

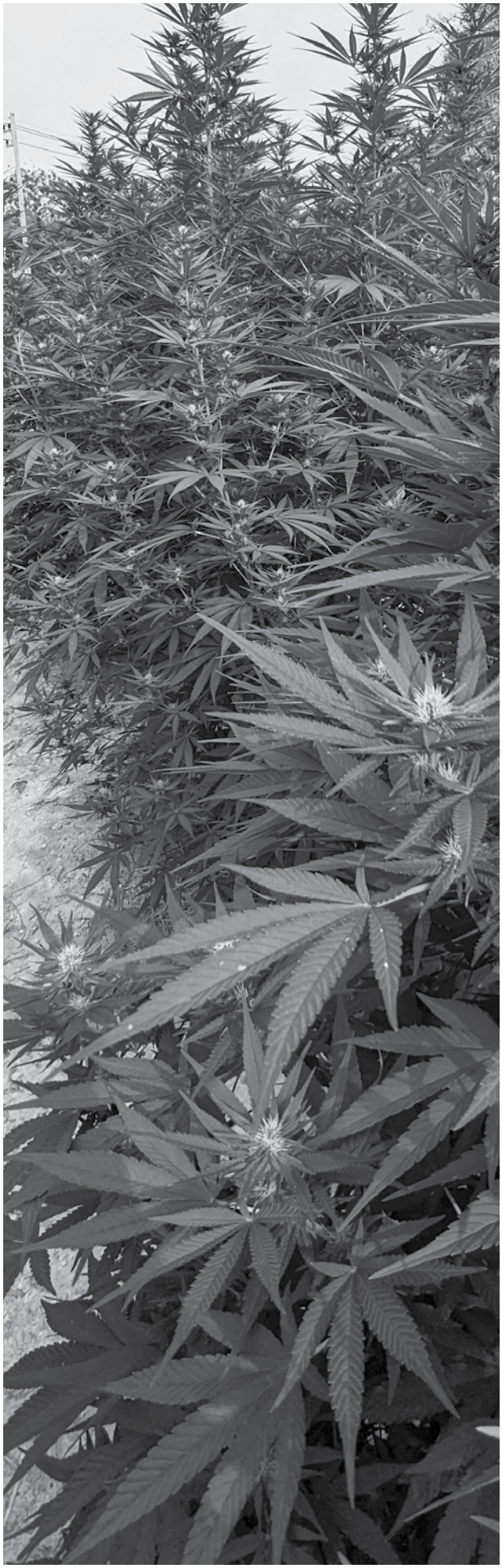
Terms used to describe compulsory drug detention and rehabilitation centers, their legal basis, and their management varies among countries. Regardless of these differences, the situation of individuals confined in these centres is far too similar. They are often arrested and detained without the benefit of sufficient due process. Conditions in the drug detention and rehabilitation centers often involve forced labour, beatings, substandard conditions and lack of access to evidence-informed health care, including for HIV prevention and treatment and for drug dependence. Some of those detained in these centers are children under the age of 18." [214]

In recent years, some Southeast Asian countries have shown tentative interest in voluntary treatment models – for instance Malaysia, and more recently Thailand's stated intention to move away from compulsory detention. Yet "voluntary" often means choosing between treatment or imprisonment, and therefore can hardly be qualified as voluntary. Therefore much improvement is needed on this front to provide quality and effective treatment that respect human rights and people's dignity.

It also needs to be stressed that the booming drugs trade in Myanmar and Southeast Asia remains both a symptom and a consequence of longstanding, unaddressed issues. Confronting these will require experimenting with new approaches. Many positive experiences already exist worldwide – supportive interventions and fairer development models that can help to address these issues.

Even as methamphetamine use rises, however, harm reduction and treatment services for problematic stimulant use remain scarce in Southeast Asia. More targeted responses are needed, including risk-reduction strategies, support for self-regulation, and referral pathways to psychosocial support and medically assisted therapy. One respondent from Thailand recommended establishing an online consultation service offering information on different drugs and their effects, while ensuring users' privacy.[215] A woman from Putao Township in northern Myanmar, who works as a manual labourer and uses drugs, urged: "Please don't arrest drug users. Create more employment opportunities. Enhance services for female drug users".

For those using methamphetamine in occupational contexts, abstinence may be unrealistic, as use often helps them cope with harsh working conditions. In the longer-term, more ambitious non-drug-related measures are necessary – legal protections, social welfare and decent salaries. Addressing problematic ATS use at work requires confronting the structural factors that heighten risks.



Cannabis plants in Thailand (KC)

4. Cannabis in Southeast Asia: Between Tradition and Reform

In Southeast Asia, cannabis remains one of the most widely-used drugs, yet national policies continue to be dominated by prohibition – with Thailand standing out as the region's only major exception. Since 2022, Thailand has allowed a rapidly expanding non-medical cannabis industry to emerge, making its regulatory environment one of the most liberal globally, even if its long-term direction remains uncertain. Elsewhere in the region, governments largely retain strict and punitive laws.

This chapter examines the evolving status of cannabis across the region, beginning with its traditional and contemporary uses – culinary, medicinal, ritual, and recreational – as highlighted in earlier TNI work and echoed in recent interviews.[1] It then examines official data and policy narratives, including their methodological limitations, political uses and inconsistencies, which mirror challenges discussed in Chapter 3 "The ATS Boom and Diversification of Synthetic Substances". The chapter also reviews medical cannabis debates, where advocacy, research initiatives and alternative policy proposals have grown despite slow legislative progress. Throughout, examples from Myanmar, Thailand and neighbouring countries illustrate how communities navigate changing landscapes. The chapter concludes with an in-depth look at Thailand's unique trajectory, where rapid liberalisation has generated both opportunity and uncertainty, and where policy direction remains fiercely contested.

Cannabis use in Southeast Asia

Cannabis is a highly versatile plant with longstanding cultural, culinary and social significance in Southeast Asia. In several communities, it is valued in the kitchen, either as both a flavour enhancer or for its psychoactive effects.[2] In Thailand, cannabis is sometimes used as a condiment in kway teeow rua (boat noodle soup), and in provincial markets in Laos and Cambodia cannabis remains a common cooking spice.[3] Marie

Alexandrine Martin's 1973 ethnography records hemp soup across the region and notes that in Cambodia "the leaves are used in diverse ways", as condiments (krueang) for curry, as vegetables (ânlwak) or mixed with fish paste fritters (prâhok). She also observed that cannabis was smoked in simple chopped form, wrapped in paper, leaves of maize or banana, or smoked through bamboo water pipes.[4]

In Vietnam, the same source found that at the time resin-based preparations (cân xa:) were mostly consumed by foreigners, and stricter controls soon followed.[5] Prior to the consolidation of prohibition in the 1970s, cannabis was largely socially accepted, and Martin notes that possession "does not constitute an offense; the normal reaction is to laugh and wish pleasure to the person who has it."[6] She argued that distrust towards cannabis emerged mainly among Westernised elites, while rural communities understood the plant within their existing knowledge systems and used it in moderation.[7]

Western colonial rule accelerated prohibition. The British colonial authorities introduced bans in Singapore and Burma in 1891[8] (later codified in the 1917 Burma Excise Act[9]), the Dutch in Indonesia in 1927[10], and the British again in Malaysia in 1952.[11] Thailand, although not formally colonised, banned cannabis in the mid-1930s through its adherence to the International Opium Convention, which was spearheaded by colonial powers. By the late 1960s, cannabis was illegal in nearly all Southeast Asian countries, a trend reinforced by the 1961 Single Convention on Narcotic Drugs and subsequent UN drug control treaties, under which cannabis was long classified amongst the most strictly controlled drugs with limited recognised medical value (until 2020).[12]

An exception briefly emerged in Burma, where in 1937 a Burmese Minister of Finance replaced the British ban with a licensing system for cannabis sales,[13] mostly targeting Indian consumers.[14] Though imperfect and rarely discussed in contemporary debates, this legal system persisted until the introduction of a new drug law in 1993, when the country's international name had been changed to Myanmar by the then military government.

Unlike opium, whose traditional medicinal uses have been better documented,[15] accounts of pre-prohibition cannabis practices in Southeast Asia are sparse. Nonetheless, widespread and diverse contemporary uses across the region point to enduring traditions. Phnom Penh is known for cannabis-laced pizzas and curries; Vang Vieng in Laos for "happy" pizzas mixing cannabis with mushrooms or opium;[16] and parts of Aceh, Indonesia, incorporate cannabis into curries, noodles, and sweets.[17] While these are sometimes framed as "cannabis tourism", they echo older culinary uses.[18]

In Thailand today, a rapidly expanding cannabis retail industry offers various edibles, snacks, drinks, and wellness products. In Yangon, Myanmar, a 20-year-old man noted that "marijuana is mixed with food, like chocolate or snacks, and sometimes even with local snacks."[19] Opium farmers from Shan



Drawing of cannabis leaves in Ambon from the 18th century

State referred to cannabis as "the laughing plant", adding that leaves are sometimes mixed with beef curry.: "if I eat cannabis beef curry I can sleep, and I can eat a whole bowl of rice."[20]

As a smokable substance, cannabis is commonly consumed in joints, with or without tobacco. In several parts of Myanmar, where herbal medicine traditions remain strong,[21] cannabis and tobacco are often rolled in cheroot leaves – cheroot cigars are emptied and refilled with cannabis and dried tobacco.

Civil society activists in Yangon report that cannabis is grown locally and also imported from Thailand. While in the past accessing cannabis might have required "the right connections",[22] more recent user interviews indicate that cannabis has become more easily accessible in places like Yangon, where it is increasingly seen as a soft drug. Users report that police tend to overlook personal use, as long as individuals smoke alone and do not disturb others. Products can be obtained through regular suppliers or secure connections, while other items like space cakes or cookies are available via online channels.[23] A 27-year-old driver in Yangon described his recent use:

> "I still use marijuana, but not to the extent that I am addicted... I use one joint for about four to five days. When I first started using, I used four to five joints a day... I check in online groups and order by phone. They deliver it."

Several locals in Pathein agreed that cannabis is becoming more common, though WY tablets remain dominant. A former Myanmar Army soldier said he prefers WY because "it



Cannabis stalks served at a hotpot dinner in Myanmar (TNI)

helps me focus and get things done" but still described the longstanding presence of cannabis:

> "[In] Pathein, marijuana was previously known as Marshi, and there was even a Marshi Gang… Their cap had a green leaf on a black background. They used to go out at night to use it before the coup."[24]

He also recalled widespread cannabis use during military postings in Karen State:

> "Marijuana is very common there, it is cheap and easily accessible. When we return to the city from the frontline, we often carry it in a 'penan eik' [large rice bag]… The locals grow it for elephants and pigs for medicinal use. They are generous, and we would ask: 'mother, can I have a little bit?', and we could take a handful. Back at the army base with our troops we roll it in an old newspaper or banana leaves. If nothing is available, we even use notebook paper from our rations. We distinguish the quality based on how the dried buds look."[25]

Cannabis prices in Myanmar vary by region, type and quantity. A 20-year-old man in Yangon said he spends "around 5,000 Kyats" (2.2 euro) but during Covid-19 prices were over twice as high. Another person noted that prices had dropped from 10,000 in 2021 to about 3,000 MMK in 2024, though often "mixed with seeds and leaves".[26] A 27-year-old male driver described two types sold in Yangon:

> "MANGO is better quality, SHAN is slightly lower … SHAN is 5,000-6,000 kyats per 10 grams, MANGO about 20,000 kyats."[27]

In Tanintharyi Region, prices are significantly higher. One man explained:

> "Weed prices depend on the strain: hybrid, indica and sativa. Thai strains cost over 10,000 kyats per gram… Hash and THC vapes are also available but vapes are very expensive; even the lowest quality starts at around 250,000 kyats (110 euro). Prices rise when the Thai Baht rises… A vape can be finished in a day if consumed strongly."[28]

According to recent reports, farmers in southern Sagaing Region are increasingly moving from traditional crops such as rice, beans and betel nut towards the cultivation of cannabis, lured by soaring profits amid deepening conflict and economic collapse. Several villages have shifted to growing hemp since 2022-23. According to locals, this shift was driven by rising costs and pest infestations in betel nut plantations.[29]

Government data and policies

Reliable data on cannabis production and distribution in Southeast Asia remains limited, and there is no standard method for estimating outdoor or indoor cultivation across the region. The World Drug Report provides annual figures on cannabis seizures and eradication – but these offer only a narrow window into market dynamics. Between 2014 and 2023, five Southeast Asian countries in (Indonesia, the Philippines, Thailand, Myanmar and Vietnam) submitted cannabis-related data. The Philippines reportedly eradicated nearly 4 million plants in 2023, while Indonesia claimed to have eradicated over 600,000 plants.[30] According to the ASEAN Drug Monitoring Report, around 4,000 tons of cannabis were seized across ASEAN in 2023.[31]

Country-level prevalence figures show that cannabis use is generally overshadowed by the use of amphetamine-type stimulants (ATS) and, in some places, opioids.[32] In Malaysia, for example, cannabis use fell from 8.82% in 2012 to 3.3% in 2018, though prevalence remains higher among teenagers (6.5%) than adults (3.4%).[33] Singaporean research similarly notes that many users initiate use during adolescence,[34] a pattern echoed in interviews conducted for this report.

In most of the region, harsh penalties and pervasive anti-drug narratives frame cannabis almost exclusively in negative terms. This shapes academic research, data collection and policy debates, with far greater attention



Woman in Himachal Pradesh in India with cannabis harvest (TNI)

paid to documenting harms than exploring the diverse meanings, practices or potential therapeutic applications of cannabis.[35]

Yet harms related to cannabis use do not occur in isolation: they often intersect with enforcement practices, inequality and criminalisation.[36] As noted in a Malaysian qualitative study, people who use cannabis tend to be more educated and in employment compared to opiate or ATS users, which lower their risk of arrest, illustrating how enforcement patterns rather than actual use largely determine who is criminalised.[37]

In nearly all Southeast Asian countries, cannabis use and possession remain criminal offences, often accompanied by imprisonment, mandatory treatment or corporal punishment. The death penalty applies for larger quantities[38] (e.g. 200 grams and above in Malaysia, though no longer mandatory),[39] and executions continue in the region, including a 2023 case in Singapore for coordinating cannabis trafficking.[40] Some governments have also tightened controls in response to Thailand's recent reforms, introducing measures such as urine testing for citizens returning from trips abroad.[41] In addition to serious human rights concerns, these punitive approaches highlight how authorities tend to overlook more realistic understandings of consumption: "personal use" includes not only solitary use, but also collective use and non-commercial sharing amongst people, yet such distinctions are rarely acknowledged in law.[42]

Beyond Thailand, where cannabis was removed from the Narcotics Code in 2022, some policymakers in Southeast Asia have considered removing prison sentences for use (e.g., Myanmar)[43], or low-level possession (e.g., Malaysia).[44] Yet these reforms often substitute incarceration with compulsory treatment, itself a form of detention documented to not only be ineffective with high relapse rates but also involve widespread human rights abuses.[45] Moreover, mandatory treatment ignores the reality that most people who use drugs do not develop problematic use and require no treatment,[46] although they may still benefit from other services such as harm reduction options – an unexplored area even in countries with more progressive regulatory systems.[47]

Cracks in the ASEAN drug consensus?

At the UN level, several developments have shifted global drug policy debates toward health and human rights: the 2016 UN General Assembly Special Session (UNGASS) on Drugs outcomes; the 2018 UN System Common Position on drug policy; increased Human Rights Council (HRC) attention, and the 2020 Commission on Narcotics Drugs (CND) vote removing cannabis from Schedule IV. Together, these changes – aligned with the Sustainable Development Goals (SDGs) – have widened opinions among ASEAN member states on drug policy approaches and fractured the long-standing consensus that once underpinned ASEAN's prohibitionist framework.

Earlier, ASEAN echoed the 1998 UNGASS target to achieve "a Drug-Free World" by 2008. Later, ASEAN delayed its own target to 2020,[48] and reaffirmed this aspiration in its 2016-2025 Work Plan. The definition of "drug-free" gradually softened, as the target was obviously not met, and member states stated it should be defined as reaching a "significant reduction of drugs". However, the overarching ideology remained intact.[49]

Regional statements at the 2016 UNGASS already showed some tension: while ASEAN collectively rejected "calls to legalise controlled drugs" and defended the conventions,[50] individual member states signalled differing interpretations. Singapore underlined its rejection of harm reduction or decriminalisation,[51] whereas Thailand adopted a more nuanced stance, supporting the conventions, but explicitly recognising the need for treatment instead of incarceration and leaving open the possibility of decriminalising non-"dangerous" drugs.[52] ASEAN Ministers initially maintained the rhetoric of unity after the 2016 UNGASS,[53] yet grievances were evident. Singapore's 2016 Chair's Statement emphasised "solidarity", thinly masking frustration over diverging positions. These divergences deepened as Thailand, and, to a lesser extent, Malaysia began exploring reform on their own.

Meanwhile, cannabis policy debates intensified globally. The WHO's review of cannabis scheduling, unprecedented in scope,[54] culminated in the close 2020 vote to remove cannabis from Schedule IV. Thailand, along with several countries with traditional cannabis histories – Nepal, India, South Africa, Jamaica and Morocco – voted in favour, a politically significant break within the Asian and African blocks, which generally oppose cannabis liberalisation.[55] ASEAN cohesion was further tested when Singapore convened a pre-vote meeting to rally opposition and vote "no".[56] The following day, Thailand voted "yes" despite this disapproval, defying bloc pressure and triggering visible friction.

In 2021, ASEAN expressed further concerns over "liberal attitudes" toward cannabis and reaffirmed its opposition to legalisation for non-medical use.[57] Thailand's trajectory – from its 2018 medical cannabis reforms[58] to the later rescheduling of cannabis and kratom, and its vote at the CND – stood in sharp contrast to ASEAN's long-standing "drug-free" narrative. The tightening of Thai cannabis rules in 2025, which introduced stricter controls to limit sales to medical purposes,[59] underscores the fragility of cannabis reform and the pull of ASEAN's dominant prohibitionist ideology. Meanwhile, harsh enforcement in states such as Singapore further shows how regional pressure and political norms shape member-state policy trajectories.

Still, subtle shifts are gaining ground. Even the 2023 ASEAN Drug Monitoring Report acknowledges that developing regulatory for medical cannabis "while controlling recreational use" could reduce harms and harness the therapeutic potential,[60] a statement that would have been unthinkable a decade ago.

According to the 2023 ASEAN Drug Monitoring Report, nearly 15,000 people arrested for cannabis-related offences that year, compared with around 31,000 arrested for opioids and 260,000 for ATS. Of more than 672,000 people who underwent drug "treatment" in 2023, fewer than 5% were treated for cannabis use.[61] It remains unclear whether the lower number of cannabis-related arrests and treatment cases reflect reduced popularity, a degree of de facto tolerance, or simply policing practices focused primarily on ATS. These figures mainly illustrate enforcement trends rather than the scale or nature of cannabis markets.

Nevertheless, lower enforcement priority is visible in some places. When cannabis was removed from the Thai Narcotics Code in 2022, about 3,000 people imprisoned for cannabis offences were released and roughly 1,000 people had their sentences reduced – a small number compared to the overall prison population (around 270.000), 73% of whom were incarcerated for drug-related offences.[62]



Cannabis buds, ready for use in Thailand (KC)

Medical cannabis in Southeast Asia: Trends in advocacy, policy, and discourse

As elsewhere, people in Southeast Asia use cannabis for recreational and therapeutic reasons. The latter use is often framed as self-medication due to the absence of formal medical cannabis systems. In several countries, medical cannabis users and caregivers have become central to drug policy reform movements, such as parents seeking cannabis-based treatment for epilepsy. In the Philippines, for instance, the prohibition regime has forced mothers to source cannabis medicines illegally, sometimes importing them clandestinely, as alternatives to antiepileptic pharmaceuticals with severe side effects. These women, together with advocates, now lead medical cannabis activism.[63]

Despite the notoriously harsh war on drugs still ongoing in the Philippines, some argue that the use of medical cannabis is to some extent allowed in the country, if one is able to obtain a "compassionate special permit" from the Food and Drugs Administration. Former President of the Senate of the Philippines, Tito Sotto, who also drafted the 2002 Dangerous Drugs Act, in 2018 said that around 50 applications (for special licenses to access medical cannabis legally) were received every year by the FDA.[64] However, the process to obtain such a special permit is highly cumbersome and complicated, as observed and experienced by some of the women who attempted to gain access to medical cannabis to treat their children's illnesses.[65]

In Indonesia, medical cannabis regulation has garnered support from some political and religious figures such as the Indonesian Ulema Council.[66] The push for medical cannabis regulation has also been led by mothers of children with cerebral palsy and epilepsy, who spearheaded a judicial review at the Constitutional Court. Although the petition was rejected, the Court instructed the government to conduct a study on the medical uses of cannabis,[67] a step that helped further normalise public discussion about its therapeutic potential.[68] Since then,



Cannabis products for sale in Bangkok (TNI)

government engagement has gradually expanded. In 2025 the national narcotics board began collaborating with Udayana University in Bali on medical cannabis research, signalling a cautious institutional shift.[69] This momentum followed an earlier case in which a man growing cannabis to treat his ill wife was arrested – she tragically died during his custody, triggering a national debate that brought medical cannabis issues further into the mainstream.[70]

Alongside such developments, there have been clandestine networks producing or distributing cannabis extracts for therapeutic purposes. In Malaysia, for example, the well-known case of Muhammad Lukman – initially facing the death penalty for supplying cannabis oil to patients – generated a major public outcry. Tens of thousands signed petitions supporting him, and on appeal he received a reduced five-year sentence.[71] Similar cases, such as "Dr Ganja", who supplied cannabis to around 800 patients,[72] illustrate a broader shift in Malaysian public sentiment toward recognising cannabis' medical potential in contexts where healthcare access is often insufficient.

Amidst the prevailing societal taboo around recreational cannabis use, a study among 462 adults in Selangor (a state of seven million inhabitants in Malaysia) found that 64% support medical cannabis decriminalisation.[73] Another qualitative study with employed graduates in Malaysia reported widespread belief in cannabis' safety and therapeutic value,[74] with 30 % of respondents using it medicinally and many perceiving fewer risks than with alcohol or pharmaceutical products.[75] At the same time, researchers noted an uncritical attitude among some users toward dependence and health effects, highlighting the need for balanced information and non-judgment support services.[76]

The aforementioned study in Selangor, Malaysia sheds light on the recurring dilemma facing cannabis-related narratives in Southeast Asia. On the one hand, the prohibitionist view puts forward the idea that cannabis – like other illegal drugs – is dangerous and therefore ought to be avoided, implying that its potential benefits are either non-existent or so limited that they would never outweigh its risks. This leads to

calls for prohibiting recreational use while allowing medical or scientific use only under limited circumstances. On the other hand, some advocates strongly promote cannabis' benefits, partly as an effort to rebut the often faulty and hyperbolic claims made about the dangers of cannabis by the prohibitionist framework. Yet, this enthusiasm can lead to overlooking risks associated with early-age use, prolonged consumption and commercialisation. Meanwhile, these opposing views cast a shadow over the need for a pragmatic, compassionate approach. As the Malaysian study showed, some users who wished to reduce intake avoided treatment due to fear of prejudice, illustrating why punitive approaches fail to address health needs.[77]

Against this backdrop, an emerging middle-ground discourse increasingly favours medical cannabis but remains cautious regarding non-medical use. In Malaysia, policy makers debating the decriminalisation of small-scale drug possession have also begun exploring regulated medical cannabis frameworks and consulting with civil society and Thai officials.[78] Interviews with pharmacists similarly indicate cautious, conditional support for medical cannabis, grounded in the need for strong regulatory controls and dedicated training for healthcare professionals.[79] Another survey among Kuala Lumpur pharmacists found that limited knowledge correlated with more negative attitudes, underscoring the need for professional education.[80]

Even in Singapore – one of the region's most punitive jurisdictions, where cannabis trafficking can lead to the death penalty – the government has permitted pharmaceutical cannabinoids (particularly cannabidiol for two patients with treatment-resistant epilepsy). Singaporean researchers are exploring cannabinoid production through engineered micro-organisms, framed as a form of "sustainable therapeutics".[81] This shift does not, however, reflect any easing of attitudes toward the cannabis plant itself, as synthetic cannabinoids can be produced without altering the criminalised status of it. Meanwhile, public attitudes are shifting: more than half of Singaporeans now support medical cannabis,[82] and younger people increasingly oppose the criminalisation of cannabis use abroad by Singaporeans citizens.[83]

In Laos, debates have also opened. In 2019 the government formed a committee to explore cannabis regulation. A 2022 Ministerial Decision allowed licensed firms to produce and trade hemp products, setting THC limits of 1% for dried flowers and 0.2% for medical-use items, which must also contain at least four times more cannabidiol (CBD) than tetrahydrocannabinol (THC).[84] Though cannabis remains prohibited under narcotics law, a 2025 joint venture pilot was granted an exclusive license to cultivate, process and export cannabis. According to an article on Tobacco Asia magazine, "if this pilot project falters, all of its assets will become government property. And if things are going well, it might lead to Laos eventually decriminalizing and legalizing cannabis in the same way Thailand did in 2021."[85] Amidst these changes, there have been reports that Thai-produced cannabis products – primarily beverages – have made their way to some shops along the Mekong River, notably in Vientiane.[86]

Regardless of what the future holds for medical cannabis in the region, what remains largely missing is discussion around harm reduction for people who use cannabis – one that is not based on forced abstinence, and one that is based on the understanding that no matter what the policy says, individuals – underaged or otherwise – will continue to consume cannabis either for recreational, therapeutic or cultural ends.

Cannabis in Thailand

Thailand has undertaken a series of cannabis policy reforms that sharply diverge from the region's typically strict approach, while remaining one of Southeast Asia's key producing countries alongside the Philippines, Laos and Indonesia.[87]

Although reforms were not officially intended to legalise non-medical cannabis, the Thai model provides space for a flexible,

Cannabis as medicine in Southeast Asia: Past and futures

Unlike China and India, medicinal uses of cannabis in Southeast Asia are less widely documented.[88] One of the few region-focused texts, a 1973 chapter by botanist M. A. Martin referred to earlier in this chapter, describes extensive medicinal uses in Cambodia and Thailand, including concoctions to stimulate appetite, induce sleep, address convulsions, migraines, asthma, dysentery, "haemorrhoids and polyps of the throat, intestines, and the sex organs", diarrhoea, and to prompt contractions during childbirth.[89] Other sources also mention treatments for gonorrhoea and diabetes in Indonesia and possibly Malaysia.[90]

The line between medicinal, cultural and psychoactive uses was often blurred. In Cambodia, cannabis mixed with tobacco was prepared on "strychnos" wood, adding elements believed to help cure coughs.[91] Hemp soup or smoked cannabis could provide a sense of well-being ("sruel khluen"),"[92] including for women post-delivery. German-Dutch botanist G. E. Rumphius's 18th century notes from Ambon, Indonesia, similarly describe cannabis tea consumed for a feeling of "hayal", similar to the modern Indonesian word "khayal" (a state of imagination or fantasy).[93] Such examples mirror long-recognised global traditions in which cannabis straddles therapeutic, ritual and recreational roles.[94]

These practices highlight challenges for contemporary medicinal cannabis. Traditional medicine does not easily conform to biomedical standards, which emphasise measurable clinical outcomes, whereas traditional healing forms part of broader cultural and spiritual systems. Neither system is inherently incompatible, but their logics differ.[95]

As cannabis researchers Hazekamp and Fischedick (2012) note, "cannabis as an herbal medicine poses serious challenges to modern medicine," which relies on a "single compound, single target" approach.[96] Therapeutic effects may be more holistic or subtle,[97] and prohibition has hindered research that could bridge these paradigms.

Thailand stands out globally for integrating traditional medicine into medical cannabis reform.[98] With long experience regulating traditional practitioners, Thailand trained both modern and traditional healers to prescribe cannabis. The Ministry of Public Health has approved 16 Thai traditional cannabis regimes. By 2022, 339 medical cannabis clinics and 449 Thai traditional medicine clinics were providing treatment.[99]

A notable example comes from Wat Chom Thong (Phitsanulok), where 98 terminally ill cancer patients received palliative treatment with "Nano Lung Tu" cannabis oil. Patients stayed at the temple with relatives between April and November 2020, growing their own food, receiving oil and learning extraction methods for continued home use."[100] The study reported an 88% completion rate – well above the researchers 50% hypothesis – and suggested improved quality of life, though specific indicators were not detailed.[101] Still, the example illustrates what a more community-based, less medicalised form of cannabis care may look like.

decentralised system permitting home cultivation, expanding traditional medicinal uses,[102] and – intentionally or not – allowing thousands of cannabis retailers to appear almost overnight, from cafés to US-style shops and clinics selling cannabis-based products.[103]

Thailand's reform began in late 2018 with a restricted medical scheme allowing low-THC CBD medicines and enabling licensed clinics to prescribe cannabis for 38 conditions.[104] Low-THC plants were removed from the narcotics list and households could grow six plants if organised into "community enterprises".

By 2019-2021, cannabis oil became available in state-run hospitals, and around 80 community enterprises – mainly in the northeast, where cannabis has long been cultivated – were registered. A lot of illicit production shifted across the border to Laos, and most compressed cannabis on Thai markets originated from Lao producers,[105] while high-THC flowers were increasingly sourced from indoor growing near Bangkok.[106].

Leading up to the general election in March 2019, the Bhumjaithai Party campaigned on wider cannabis reform, presenting it as a potential "cash crop" for farmers and later pushing for full removal from the narcotics list. Party leader Anutin Charnvirakul, who became Minister of Public Health, kept promising to take cannabis off the list of narcotic drugs completely, which was finally approved in January 2022. Finally on 9 June 2022, the public effectively gained freedom to use, possess, grow and sell cannabis without punishment. All past cannabis offences were expunged, releasing and reducing sentences for thousands of people.[107] No explicit prohibition on non-medical consumption was imposed, but minor restrictions later followed, such as fines for public nuisance and bans on sales to minors, pregnant women and breastfeeding mothers.

Within months, an estimated 2,000 dispensaries opened – mostly in Bangkok – selling flowers and a wide array of infused products,[108] some with THC levels exceeding the legal 0.2% THC threshold.[109] Dispensaries



Cannabis shop in northern Thailand (TNI)

were generally sleek and tourist-oriented, with prices ranging from THB 200 to 800 (5 to 20 euro) per gram,[110] higher than the longstanding illicit market where prices averaged THB 100 (2.7 euro) per gram.

Mixed reactions

Thailand's reforms have been praised for breaking with regional orthodoxy but criticised for enabling rapid increases in visible cannabis use and associated harms. A 2019-2021 study reported rising use of cannabis-containing food and drinks, and increased smoking among 18-19-year-olds.[111] Cannabis use-related problems rose in 2020, but declined later. Researchers suggest that this was due to heightened public awareness on side effects, partly due to the wider availability of potent cannabis products.[112] Regardless of such data, it is important to note that preferences around potency, frequency and routes of administration vary widely and may be shaped by factors such as age, health status, profession and personality.[113] Concerns have also grown over the lack of standardised regulation,[114] especially around strong concentrates and edibles, poorly labelled products, and marketing.[115]

While most attention has focused on recreational markets, medical cannabis use in Thailand remains substantial. A 2022 study involving 485 people using cannabis for conditions such as cancers, neuropsychiatric symptoms and chronic pain found that 74% sourced cannabis illegally – from traders, friends, relatives and clandestine growers – while only 26% obtained cannabis from certified healthcare providers.[116] This mirrors trends in other countries where formal schemes coexist with thriving informal markets.[117] Whether such illegal sourcing has to do with the relatively high prices of legal cannabis, administrative barriers or other reasons remains unclear.

More positively, Thailand's official medical cannabis programme shows promising results. A study of over 21,000 patients treated with Ministry of Health certified cannabis oil reported improved quality of life for hypertension, diabetes, cancer, depression, insomnia, migraines and chronic pain.[118] Such programmes help standardise care, ensure safer products, and generate essential data on patterns of use. Thai researchers are also exploring the use of CBD in treating people faced with methamphetamine use-related problems, and in some hospitals they are comparing the results of the use of CBD for stimulant-use disorders in comparison with the antidepressant Bupropion.[119]

Cannabis in Thailand at a crossroads?

On 9 June 2022, the government launched an online application to keep track of the number of cannabis growers, and to enable individuals to apply for a digital certificate prior to cultivating cannabis. More than 9 million people registered on the first day, leading the application to crash.[120] In addition to allowing at-home cannabis cultivation, the Thai government has also distributed cannabis plants. These reforms built upon Thailand's already existing system of licensing and regulation for cannabis cultivation for medical and industrial purposes. Governed under the auspices of the Ministry of Public Health and the Food and Drug Administration, this licensing system is deemed as too bureaucratic and complicated by some, hence inaccessible for small-scale actors whilst largely favouring government (-affiliated) actors.[121]

Additionally, Thai cannabis growers and sellers have expressed concerns about the fact that many cannabis shops are not locally owned, and more importantly about the rise of illegal imports of cannabis from the United States, much of which has been flooding Thai dispensaries whilst sidelining locally produced cannabis. In May 2023, Al Jazeera reported that a "cannabis dealer-turned-legal entrepreneur said he invested heavily in making his own soils and fertiliser, only to find that his cannabis is too expensive for a market filled with cheap imports."[122] In addition, capital-rich business and criminal actors from abroad have been coming to Thailand, establishing production facilities whilst taking advantage of Thai cheap labour



Cannabis plantation in Thailand (KC)

to produce cannabis, much of which also for the international (illegal) market.[123]

The regulatory vacuum has left space for reckless business practices, contributing to rising reports of poisonings and underage use.[124] On the other hand, only a portion of cannabis businesses have been able to stay afloat, let alone thrive. According to Kitty Chopaka, an early day Thai cannabis activist, "many shops survived by selling nicotine vapes and illegal edibles" in addition to "doing things that they said that they would never do, like selling to minors."[125]

Farmers faced plummeting farm-gate prices too: before June 2022, cannabis flowers sold for THB 5;000-7,000 (135-190 euro) per kg; a year later, oversupply pushed prices down to THB 500-2,000 per kg.[126] Some farmers could not sell their harvests at all and reverted to other crops.[127] Retail businesses also slowed sharply from mid-2023, with some reporting over 80% declines in sales.[128]

Political uncertainty deepened after the 2023 elections. Although the Move Forward Party, which secured the highest number of votes, proposed re-listing cannabis to curb recreational use pending a more comprehensive Cannabis Act, the party was unable to form a government. Under Prime Minister Srettha Thavisin (Pheu Thai), the cannabis market faced renewed pressure, including crackdowns on unlicensed shops and efforts to restrict use to medical contexts.[129] In August 2023, authorities shut down 13 unlicensed dispensaries in Phuket and annulled over 200 licenses elsewhere,[130] although critics noted that enforcement disproportionally targeted small vendors rather than major importers.[131]

In January 2024, the government released a draft Cannabis and Hemp Act that would prohibit recreational use, impose fines up to THB 60,000 (1,600 euro), restrict marketing and require licensing for production and distribution.[132] A later version went even further, also requiring medical prescription for cannabis use.[133] Supporters argued that the bill could curb over-commercialisation, while critics warned it threatened personal freedoms and did little to address deeper inequalities in the cannabis economy. Meanwhile, dispensaries remained subject to reporting requirements on every sale and purchase, with operators noting the system already offered a functional degree of oversight.

By mid-2025, the policy landscape shifted again. In June, Public Health Minister Somsak Thepsuthin imposed strict controls aimed at limiting use to medical purposes, closing more than 2,000 unlicensed shops and requiring licenses for possession, production, trade and research. Medical access was limited to five conditions,[134] and the reclassification of cannabis seemed imminent.[135] Then, in September 2025, Anutin Charnvirakul – the architect of the 2022 reforms – returned as

A brief overview of key cannabis developments in the wider Asian region

While Southeast Asia continues to navigate fast-changing cannabis markets, notable shifts have also occurred elsewhere in Asia. South Korea became the first East Asian country to legalise medical cannabis in 2018 for narrowly-defined conditions such as epilepsy and severe pain, designating Gyeongbuk province (2020) as a special cannabis-production zone.[136] Japan, which historically penalised only possession and trafficking, introduced criminal penalties for cannabis use in 2024, while simultaneously opening the door to limited medical cannabis treatment.[137]

In South Asia, cannabis retains strong cultural and medicinal significance. India, despite being party to the 1961 Single Convention, continues to allow regulated use of "bhang", a traditional preparation taken especially during festivals,[138] though broader legalisation debates have gained little traction. In Nepal, cannabis remains illegal but widely used in religious and rural contexts. Calls for legalisation have grown, driven by economic and medicinal arguments.[139]

Elsewhere, Taiwan and Hong Kong maintain strict anti-cannabis laws that reflect regional resistance toward recreational reform. However, rising consumer interest in CBD has pushed governments to clarify rules, restricting CBD to near-zero THC products. Japan has seen the opening of CBD cafés with near zero THC products[140]. Meanwhile Hong Kong moved in the opposite direction, banning CBD altogether and imposing fines and prison terms for possession or consumption in 2023, citing concerns over potential THC contamination.[141]

Overall, developments across Asia form a patchwork of approaches shaped by cultural traditions, economic ambitions and public health debates. While medical cannabis is slowly gaining ground, recreational legalisation remains distant in most countries.

prime minister, restoring cautious optimism among industry actors that cannabis would remain decriminalised under tighter regulation.[142]

By early 2026, however, the tightening of regulation had already reshaped the sector. Cannabis flower was classified as a "controlled herb", meaning sales required a prescription from a licensed medical professional and were limited to a 30-day supply. Tourists could still access medical cannabis, but only after consultation with a Thai doctor. Dispensaries also faced stricter operating conditions, including requirements to employ licensed medical professionals. By December 2025, Thailand still had 18,433 cannabis shops nationwide, but more than 7,000 operators whose licences expired in 2025 chose not to renew them.[143]

These drastic yet bumpy shifts show how precarious Thailand's cannabis reform remains. Farmers, small businesses and consumers who benefitted from expunged records and home-growing rights face renewed uncertainty. Recent developments suggest that Thailand's cannabis sector is moving toward a more medicalised and compliance-heavy framework, butven if non-medical cannabis is restricted, it is unlikely to disappear. Rather, markets will adapt – as quickly as dispensaries first appeared when cannabis was delisted.



Wild kratom trees in West Kalimantan, Indonesia (YP)

5. The Kratom Paradox: Trade and Prohibition in Southeast Asia

Kratom ("Mitragyna speciosa") is a tropical tree indigenous to Southeast Asia, growing wild or cultivated in Thailand, Malaysia, Myanmar, Indonesia, Papua New Guinea and the Philippines. It is known locally as "kedemba" or "puri" in Kalimantan, Indonesia;[1] "krathom", "kakuam", "ithang" or "thom" in Thailand; "biak" or "ketum" in Malaysia; and "mambog" in the Philippines.[2] Communities have long used kratom leaves for traditional medicine (such as fever, pain and diarrhoea), wounds and skin care,[3] enhancing energy and productivity, and, in some cases, for construction materials and environmental management.

This chapter examines key trends related to kratom in Southeast Asia, with a primary focus on Myanmar, Indonesia and Thailand. It explores patterns of consumption alongside selected aspects of production and trade. The chapter also considers common health concerns and assesses how kratom-related policies intersect with broader questions of community well-being and welfare.

Kratom has both stimulant and sedative effects depending on dose, useage and setting. Leaves are chewed, taken as powder or brewed as tea. It is also mixed with substances such as soft drinks, cough syrup or pharmaceuticals. Low dosage use of leaves has a mildly stimulating psychoactive effect often compared in intensity to betel nut. Higher doses of kratom, on the other hand, tend to produce more sedative effects. More recently, kratom has gained prominence for helping manage opioid and other drug withdrawal symptoms, pain and mental health conditions. Scientific evidence is growing but still limited.[4] Nonetheless, therapeutic uses, risks and user testimonies are increasingly documented,[5] from North America and Europe to Southeast Asia.[6]

Kratom is not scheduled under UN drug conventions. Yet several governments, particularly in Europe and the U.S, have in recent years moved to restrict or prohibit

it. In Southeast Asia, kratom is controlled to varying degrees. Myanmar lists the plant as a controlled drug, mirroring Thailand's scheduling of the drug before its removal from the least restrictive Category V in 2021. Singapore places kratom's main alkaloids – mitragynine and 7-hydroxymitragynine – under the strictest schedule of the 1973 Misuse of Drugs Act.[7] Malaysia classifies mitragynine as a psychotropic substance under the Poisons Act 1952, making possession, processing, transport, import or export illegal, though cultivation remains technically lawful.[8] Recently, Malaysia's Substance Abuse Council has pushed for kratom's inclusion under the country's Dangerous Drugs Act due to concerns over "ketum water" misuse."[9]

Kratom in Indonesia

Indonesia is one of the world's largest kratom producers and exporters, mainly supplying the United States and Europe. According to Indonesia's Ministry of Health (2019), roughly 90% of kratom products in the US originate from Indonesia.[10] Pekrindo, the Indonesian Kratom Entrepreneurs Association, reports that West Kalimantan exported 3,600 tons of kratom in 2017 and 4,800 tons in 2018, reaching markets in Asia, Europe and North America.[11]

Cultivation is concentrated in West Kalimantan's Kapuas Hulu Regency – home to roughly 250,000 people – where kratom plantations cover about 46,770 hectares, comparable to the area planted with rubber in the same territory. Over 46,000 farmers are involved in its cultivation, with more than 113 million kratom trees documented by the Ministry of Health in its 2019 report on kratom.[12] Most people active in the kratom economy have limited formal education and rely heavily on traditional agriculture, forestry and fisheries.[13]

Locally, kratom has long been used as traditional medicine to lower blood pressure, relieve pain and tiredness, reduce alcoholism cravings, and treat conditions such as impotence, wounds, itching, cough, diarrhoea, abdominal pain, fever and diabetes. Most use it primarily to enhance stamina.[14] In parts



Kratom leaf processing facility in West Kalimantan, Indonesia (YP)

Kratom: More than a psychoactive plant?

Every plant species – psychoactive or otherwise – plays a role in the ecosystems where it grows. In Southeast Asia, kratom trees thrive in rainforests, helping absorb excess moisture, maintain soil nutrients and provide habitat for animals.[15] As part of forest ecosystems, kratom also supports carbon storage and overall ecological integrity.

In Thailand, kratom is listed as a protected plant under the Forest Act, and cutting it requires official permission.[16] In Indonesia's West Kalimantan Province, where deforestation has intensified, kratom has gained recognition for its ecological importance.[17]

Amidst regulatory uncertainty in Indonesia,[18] the Ministry of Environment and Forestry has collaborated with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) through a Forests and Climate Change Programme (FORCLIME), which allows local communities to select plants for reforestation efforts. In Kapuas Hulu, many chose kratom because of its fast growth, long-standing presence in the area, and resilience in water-logged soils along riverbanks, where it helps prevent erosion.[19] Kratom's income-generating potential is viewed as an added benefit and aligns with parliamentary discussions about expanding non-timber forest products. Between 2016 and 2021, more than 1.7 million kratom seedlings were planted under the programme.[20] It promotes agroforestry principles and, while kratom agroforestry generates less income than monoculture (according to programme economic analyses),[21] it is significantly less environmentally damaging and ultimately more sustainable.

In West Borneo, kratom is used not only as in psychoactive or medicinal preparations but also as a local source of construction material, according to Pekrindo, the Indonesian Kratom Entrepreneurs Association.

of Kapuas Hulu, kratom powder or leaves are boiled and consumed – sometimes with honey or orange juice – while fresh leaves may be crushed for topical treatments. In East Kalimantan, the Bentian people use kratom ("bengkal") for skincare, and the Segai and Berau people employ it in childbirth-related potions and to combat fatigue.[22]

Kratom has also been found in other regencies in West Kalimantan – Melawi, Ketapang, Sintang, Sekadau, Sanggau, Landak, Bengkayang, Sambas and Kubu Raya – and in several other provinces across Sumatra and Kalimantan, including East, Central and South Kalimantan, North Sumatra and Aceh.[23]

Although kratom grows wild and has long been used traditionally, its commercial and export-oriented production in West Kalimantan expanded over the past 15 years.[24]

Before kratom's rise, many farmers depended on rubber and palm oil. With falling rubber prices, environmental concerns (especially in Europe) around palm oil, and rapidly increasing foreign demand, kratom became an essential livelihood cash crop – particularly for meeting basic needs such as food, schooling and health expenses.[25]

A 2020 survey by West Kalimantan's provincial research and development agency showed kratom contributed around 84% of household income across six Kapuas Hulu districts, compared to 11% from other agricultural work and 4.5% from non-agricultural labour. These livelihoods include milling, transportation, nurseries, wage labour[26] and harvesting from forests.[27]

Kratom has never been criminalised under Indonesia's drug law, but since 2004 it

has been included on the Food and Drug Administration's list of items prohibited in traditional medicines and supplements – a legislation which was renewed in 2016. The rule does not criminalise kratom consumption or export.[28] Rather, it restricts domestic commercial manufacturing, which continues in a regulatory grey area.[29]

Rising popularity led Indonesia's National Narcotics Board (BNN) to classify kratom as a New Psychoactive Substance in 2017 and to push for placing it under Schedule I of the drug law.[30] Authorities initially set a five-year transition period to end kratom production by 2022, later extending this to 2023,[31] and then 2024,[32] after strong objections from local governments, communities and even the Deputy Minister of Environment and Forestry. Media coverage surged, with many officials highlighting kratom's medicinal and economic potential.[33] In 2019, after commissioning a national study, the Ministry of Health reaffirmed that kratom is not a controlled substance. That same year, a new regulation clarified its legal status[34] and, in 2020, the Ministry of Agriculture listed kratom (with cannabis) as a herbal medicine commodity.[35] Despite this, contradictory statements persisted, with some authorities exploring regulatory options,[36] while the BNN continued advocating a ban, sometimes in concert with Singapore and Malaysia.[37]

Tensions increased when the United States Food and Drug Administration (FDA) imposed an import alert, threatening to block kratom shipments from Indonesia. Indonesian officials publicly criticised the move. In September 2023, the President's Chief of Staff requested that the FDA lift the alert, promising stronger quality control.[38] In November 2023, the governor of West Kalimantan then wrote to US President Joe Biden warning that "an import ban could harm more than 250,000 farmers and possibly result in the loss of 21 million kratom trees – with implications for fragile rainforest ecosystems." President Joko Widodo later reinforced these concerns during a US visit.[39]

A major shift occurred in September 2024, when Indonesia's Ministry of Trade issued a regulation creating a formal framework for kratom production and export, including quality-control mechanisms and added-value requirements. The regulation focuses exclusively on the export sector and does not cover domestic consumption. In the same period, the National Research and Innovation Agency (BRIN) announced research on kratom's analgesic potential and possible applications for diabetes and cancer.[40] This research was shared with the Indonesian Food and Drug Administration and appears to have contributed to an October 2025 partnership between BRIN and an Indonesian pharmaceutical company to develop kratom-based extracts for pain relief.[41]

Kratom in Thailand

Thailand is another Southeast Asian country where kratom holds long-standing cultural, traditional and socioeconomic significance. Initially used in the 19th century among Muslim communities in the south, it subsequently became widely consumed as a mild stimulant, brewed as tea or coffee, or chewed. As kratom's popularity expanded, multiple local names emerged, including "Thom", "E-Thang", "Ketum", "Kratom-Koke" and "Maeng Da Leaf".[42]

Kratom is commonly used in Thailand among working people to enhance stamina and productivity, particularly in physically demanding jobs. Its low cost compared to commercial stimulant drinks contributes to its popularity among agricultural labourers. A study in southern Thailand found that 85% of kratom users in Tambon Namphu in Surat Thani Province consumed it mainly to support their physically heavy work, with 16.7% first using it on rubber plantations.[43] Most users chew and spit the leaves, citing reasons such as being able to work harder, tolerate heat and reduce fatigue.[44] In many communities, kratom use is associated with diligence[45] is seen as a desirable trait in a partner.[46]

A 2017 online survey of 1,058 respondents reported that 84% of the general public had indirect knowledge or experience of kratom; 74.8% had tried kratom leaves and 56.4%

kratom decoctions.[47] Beyond work-related use, kratom drinks are consumed socially and served to welcome guests in parts of southern Thailand. Chewing kratom leaves is common in Thailand's southern and central regions, similar to drinking coffee or chewing betel nut.[48] Among some Muslim communities, kratom functions as an alcohol substitute, and in some villages it is incorporated into religious rituals.[49]

Kratom also has a long history of medicinal use in Thailand. Traditional pharmacopoeias (publications listing medicinal preparations and how to use them) from the 1650s describe kratom as a remedy for stomach ache, diarrhoea and opium withdrawal.[50] Other sources have documented its use to treat diabetes, pain, cough and parasites.[51]



Dried kratom leaves in Thailand (KC)

However, more recent consumption patterns have public concerns – most notably the 4x100 ("sii koon roi") kratom cocktail, popular among young people. This mixture typically combines kratom tea with cough syrup and Coca-Cola, and sometimes also other substances such as anxiolytics, antidepressants and analgesics.[52]

In Thailand, kratom was first outlawed through the Kratom Plant Act of 1943 and later under the 1979 Narcotics Drugs Act. Arrests linked to kratom use and possession rose sharply – from about 6,000 in 2009 to nearly 19,000 in 2018, while cases involving kratom mixes increased from under 3,000 to more than 15,000. Enforcement concentrated in the south deepened tensions with local Muslim communities, whose cultural practices were criminalised, and reinforced stereotypes linking kratom users to separatism.[53]

Mounting concerns over drug policing, prison overcrowding and community tensions spurred reforms. Between 2016 and 2017, the Thai Office of the Narcotics Control Board (ONCB) supported participatory action research in six villages of Tambon Namphu, where kratom use is widespread.[54] Most residents favoured decriminalisation, and the project helped establish a community-based kratom control system in Donsai. Here a local law mandating community leaders to safeguard residents' well-being enabled village forums that were organised to develop norms allowing traditional kratom use, protecting local ecology, and restricting practices seen as harmful, especially among youth.[55]

The process culminated in the Donsai Village Charter, which limited each household to three kratom trees, prohibited replacement planting, barred youth consumption, restricting taking kratom outside the village, and allowed only fresh-leaf use according to traditional customs. Possession was banned for those violating the Charter or using other illegal drugs.[56] Although restrictive – especially regarding modern kratom preparations – the participatory process built local ownership. Authorities considered it to be a success as the charter reduced kratom

Kratom, health and well-being

Across Malaysia, Thailand and Myanmar, kratom has long been used as traditional medicine, while its cultural, recreational and spiritual roles continue to support communal well-being.[57] Over the past two decades, however, new consumption patterns have drawn public-health attention even as scientific and commercial interest has grown.

Kratom contains more than 40 alkaloids, with mitragynine and 7-hydroxymitragynine being the main ones present. Mitragynine is dominant – up to 66% – in Thai leaf extracts,[58] 54% in Kapuas Hulu (Indonesia),[59] and 12% in Malaysia.[60] Although kratom has opioid-like properties, mitragynine behaves differently from classical opioids such as morphine, heroin or fentanyl: it is less commonly associated with dependence than classical opioids and may even reduce morphine self-administration. [61] By contrast, 7-hydroxymitragynine shows clearer dependence liability.[62]

Its many active compounds make kratom's pharmacology complex and its effects variable. As described in one study, this variability makes dosage thresholds difficult to define.[63] Effects range from mild stimulation to sedation, depending on dose, personal physiology and context of use.

As with any psychoactive substance, kratom has benefits and risks shaped by an individual's health, their mode of use and whether it is combined with other substances.[64] Some side effects must be interpreted contextually. In southern Thailand, regular users describe "rain panic"[65]: aches, chills, coughing and trembling during cold weather.[66] This phenomenon appears linked less to kratom itself than to the demanding labour conditions of rubber plantation workers who use kratom to work longer in the heat, but become more physiologically vulnerable during rainy and cold weather.[67]

Understanding why people use kratom is crucial. In Southeast Asia – especially Thailand – it is typically used to increase stamina, reduce fatigue or cope with work demands. The socioeconomic dimension is often overlooked when the term "addiction" is applied. Researchers note that some labourers wish to stop or reduce kratom use and do not meet criteria for medical dependence, but cannot afford to stop because their livelihoods depend on extended work hours.[68] Studies among these working populations show that complaints related to long-term chewing or tea consumption are relatively rare.[69]

Clinical research being limited, experts remain cautious, but evidence is growing regarding kratom's therapeutic potential. Reports from Southeast Asia and abroad suggest it can ease opioid withdrawal or substitute for riskier opioids,[70] while laboratory studies have identified anticancer and antioxidant compounds.[71] In northern Malaysia, people report using kratom to reduce heroin intake, manage withdrawal or because it is cheaper.[72]

Thai researchers have further examined kratom's therapeutic value using brainwave and movement studies. Animal research indicates that kratom may rival fluoxetine (a type of SSRI antidepressant)[73] in alleviating ethanol withdrawal and that extracts have

antidepressant-like effects,[74] reduce morphine withdrawal symptoms, and diminish methamphetamine-seeking behaviour.[75] Follow-up studies on human kratom chewers revealed potential benefits for heart-rate variability, sleep and management of methamphetamine and heroin dependence.

Outside Southeast Asia, kratom has gained popularity in Europe and North America both as a recreational drug and an alternative to prescription medicines.[76] Many dependent users report prior substance use disorders or chronic pain and seek kratom as a way to avoid or reduce opioid use.[77]

cultivation and arrests. The model was later replicated in 135 villages, leading to the adoption of the Tambon Namphu charter in November 2017.[78]

National reforms followed. In 2018, the amended Thailand drug law not only allowed medical use of cannabis but also of kratom.[79] Kratom had already been permitted for research.[80] Then, in 2021, both plants were removed from the narcotics list, resulting in thousands of prosecution cases being dropped and the release of 121 prisoners.[81] The 2022 Kratom Plant Act then formally legalised possession and consumption while regulating advertising and commercial activities, including import and export licensing.[82]

Even before the full reform had taken place, vendors selling kratom plants had appeared in Bangkok and online platforms like Shopee, where fresh leaves were widely marketed.[83] This enabled consumers to brew kratom tea and encouraged small-scale entrepreneurs to create kratom beverages. Subsequently, concerns emerged around sales to minors and vending-machine distribution. But these legal changes brought long-standing domestic use and local trade into a semi-regulated space.

In the following years, this has not produced an export-oriented industry. Compared to the cannabis boom in Thailand, the kratom retail trade has expanded only modestly. Experts attribute this to kratom's roots in community initiatives, its association with working-class users rather than tourists or urban elites, and the prevalence of simple, traditional preparations. While some shops now sell both cannabis and kratom, cannabis remains far more visible. Kratom's lower commercial profile also reflects its more limited global popularity and the absence of a broad, high-end market.

Kratom in Myanmar

In Myanmar, kratom is most common in Mon State and Tanintharyi Region, and is also familiar among Karen communities. It is known locally as "Bein Sa Ywek" (Myanmar), "Ahma Pharon" (Mon) and "Bai Lar" (Karen).

Communities have long used kratom as a traditional medicine. As one Karen elder from Tanintharyi recalled:

> "When I was a child, we had no western medicines… [we plucked] some leaves from kratom trees and boiled them, and we recovered quickly. We still use kratom tea today to treat coughing, diarrhoea and diabetes."[84]

As in Thailand, many people rely on kratom to cope with demanding work, particularly in rubber plantations, fishing, transport or daily wage labour. Although kratom has deep cultural roots, some law enforcement officials argue that workers adopted kratom in Thailand and brought the practice home, contributing to widespread use, even in monasteries. A 42-year-old man in 2024 confirmed that kratom is now among the most common substances in Mon State capital Mawlamyine, sometimes consumed alongside methamphetamine.

On the Mon coast, Bamar migrant fishers working on bamboo rafts use kratom to withstand long hours at sea as explained by an owner of several fishing rafts:

> "This is a very hard job they do. I grow kratom plants in my compound to provide its leaves to my workers on the rafts. They drink it as a tea, to help them work longer hours and to build their resilience to extreme conditions on the raft. Sometimes they also chew the leaves. I mainly grow kratom for my workers, but sometimes I also take it. We do not see any negative consequences from using kratom."[85]

In remote Karen communities of the Myeik archipelago in Myanmar's southern Tanintharyi Region, kratom use is woven into everyday life and is not viewed as "drug use". Chewing leaves or drinking kratom infusions with neighbours is considered as ordinary as betel nut chewing or tea drinking. Most users maintain work, family and financial responsibilities without difficulty, and kratom carries little stigma. For some young people, kratom can serve as a milder and more affordable substitute for methamphetamine. One former ATS user explained:

> "I used ATS while working in Thailand, but after returning home I had no income, so I switched to mixed kratom tea. It feels less dangerous, and I can work, eat and sleep well."[86]

People who use kratom in Mon State describe benefits such as improved appetite, sleep and relief from feelings of intoxication. Documented negative effects tend to be mild and linked to heavier or prolonged use – such as constipation, weight loss, insomnia, skin pigmentation and reduced libido.[87] Withdrawal symptoms, when they occur, are usually described as manageable, including joint pain, sweating, sleeplessness, decreased appetite and watery eyes.[88]

People who use kratom in more traditional ways commonly boil the leaves into tea or chew them. In Mon State, kratom is sold per 100 grams or per kilogram, or in bundles of 50 or 100 leaves. Powdered kratom is also common, typically sold in a 350-ml condensed milk can. According to a 42-year-old man in Mawlamyine: "In 2015 one bundle of 100 leaves cost 7,000-8,000 kyats (4 euro); in 2021, it was around 10.000 kyats, and by 2024, about 15,000 kyats."[89] In Mudon Township,



Kratom prosessing company in Thailand (KC)

Kratom in Mon State[90]

Kratom use has been part of Mon cultural life since the early 20th century, particularly in Mawlamyine, Mudon, Thanbyuzayat, Chaungzon, Kyaikmaraw and Mon-inhabited areas of Karen State such as Kawkareik and Kyainseikgyi. Since early 2020, previously rising WY (popular methamphetamine brand) use among Mon youth has showed signs of slowing down, coinciding with expanding kratom use, according to local workshops and community reports.

Cultivation is most widespread in Tanintharyi Region, followed by the hills around Mudon in Mon State and Kyainseikgyi in Karen State, with additional production observed along the Myawaddy-Kawkareik highway. While some households grow a few trees for personal use, most kratom supplied in Mon communities is transported from areas near state boundary lines. Dried leaves powder also reaches Yangon, Mandalay and other major cities through informal trade routes.

Several factors have facilitated the expansion of kratom cultivation and use. Since the 2021 military coup in Myanmar, armed resistance against the regime sprung up across the country, and law enforcement agencies have prioritised arms and ammunition over drug trafficking, creating an environment in which kratom transport faces limited scrutiny. At the same time, competition between WY and kratom markets have generated social tensions. In some areas, corrupt local officials have been reported to protect WY traders while targeting kratom farmers with extortion or disproportionate penalties. A resident of Khawzar town in Mon State, for instance, described being threatened with a five-year prison sentence for growing a single kratom plant unless he paid a bribe of 5 million Myanmar Kyats (1,100 euro).

Within Mon communities, views on kratom remain divided. Many regard it as a medicinal plant and a safer substitute for alcohol or WY, supporting productivity and stamina under harsh working conditions. Others, influenced by prohibitionist narratives, view kratom as an illicit drug that should be criminalised. These conflicting perspectives have created a legal and social impasse.

Despite limited formal research, community members report that kratom use has reduced social harms, including domestic violence linked to alcohol or WY use. A student from southern Ye Township explained that after developing problematic WY use and undergoing rehabilitation, he remained abstinent from WY by drinking kratom tea, which helped stabilise his daily life.

Patterns of use continue to evolve. Kratom infused with Coca-Cola and sometimes also with cough syrups has become widespread – considered safer by locals than earlier mixtures containing highly harmful additives such as mosquito coils, glue or mercury powder. At the same time, many people continue to consume kratom in its least processed forms by chewing leaves or drinking simple brews, which has helped soften negative perceptions and normalise kratom as a traditional remedy.

Kratom use is thus increasingly recognised among Mon communities for its medicinal and social roles. Yet persistent calls to classify the plant as a dangerous drug – and the ongoing polarisation around its legal status – risk creating new harms for local communities. These tensions underscore the need for comprehensive, evidence-based data collection and dialogue to inform future policy decisions.

locals noted that a kilogram of fresh leaves sells for MMK 20,000-30,000.

Price increases were also reported in Myeik, Tanintharyi Region. A 50-year-old man fishing diver recounted: "In 2020-2021, a can of kratom powder cost about 2,000 kyats but now it's 7.000 kyats." Several interviewees also explained that kratom prices fluctuate with policing: "If there is an arrest the price goes up again; if not, the price goes down."[91]

In Mon State, most forms of kratom use that do not involve mixing with other substances are broadly tolerated and often seen as socially acceptable. Parents and local authorities distinguish between "productive" use – consumption to enhance work performance – and recreational or desire-driven use, particularly kratom cocktails among young people which tend to attract more negative reactions.

As mentioned earlier, kratom is illegal in Myanmar and listed under the 1993 Narcotic Drugs and Psychotropic Substances Law. In Mon State, people who use kratom face arrest, and possession of more than six grams can result in prison sentences ranging from five to 15 years. Children and teenagers caught using or possessing kratom also risk arrest, suspension or expulsion from school. Local civil society groups note that kratom is one of the most commonly used psychoactive substances in school and youth environments (alongside ATS, tobacco, and betel nut), including among some teachers. However, harsh sanctions – especially for minors – appear to do more harm than good, particularly in settings where health services, harm reduction and accessible education support remain limited.

Kratom cocktails and stigma

In recent years, the use of kratom cocktails among Southeast Asian youth has raised public health, legal and social concerns. Recipes vary widely and are often prepared by



Kratom powder in Thailand (KC)



Making kratom tea in Mon State (MDPT)



Harvesting Kratom in Indonesia (YP)

users themselves. The best known mixture, the "sii koon roi" (4x100) cocktail in Thailand combines kratom tea made from kratom leaves with cough syrup,[92] Coca-Cola and ice,[93] sometimes with additional pharmaceuticals as antidepressants, anxiolytics or analgesics.[94] In Malaysia, a similar drink known as "koroi" is made from kratom juice, Coca-Cola and cough syrup.[95] In Mon State, Myanmar, kratom powder is used in a cocktail called 'Asean', mixed with Coca-Cola, cough syrup, yogurt and coffee.[96] Media reports occasionally mention more harmful adulterants (such as crushed mosquito coil or gas from bulbs), but consistent evidence for these claims is lacking.

Despite these mixtures containing multiple psychoactive agents, kratom is frequently singled out as the main source of harm, obscuring how other ingredients – and their interactions – in reality drive the main risks. Moreover, criminalisation has done little to prevent the emergence of these cocktails (echoing trends seen in "happy water" in Southeast Asia[97] or "tusi" in Latin America).[98] Instead, prohibition has intensified punishment and stigma, pushing people who use kratom further from needed health or social support. In some rural parts of Mon State, teenagers caught using kratom face school expulsion or even imprisonment, according to civil society representatives in Mon State.

Motivations for using kratom cocktails vary. Some young people use them as substitutes for alcohol or other drugs; others use them to cope with dependence on other substances or to manage stress.[99] Curiosity and recreation also play an important role. While kratom cocktails carry greater health risks than the sole use of kratom, allowing only the latter while heavily sanctioning the former may be counterproductive.

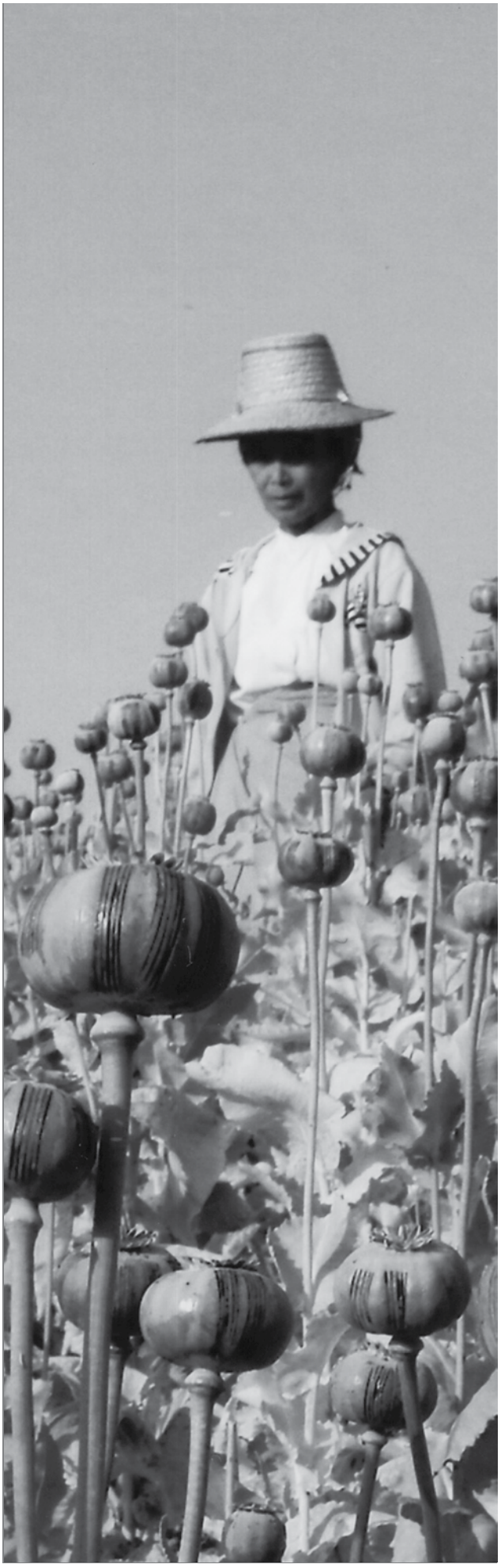
Whatever their reasons for use, people consuming kratom cocktails need non-coercive access to health, education, harm reduction and social services, including drug or mental health treatment. More scientific evidence on kratom and its interaction with other substances is therefore essential for better risk assessment and management.

Kratom policy dilemmas at the international level

As kratom is not scheduled under international control treaties, UN Member States are not required to criminalise its cultivation, use or trade. Nonetheless, national legal approaches vary widely. In the United States, kratom is legally regulated in several states while others have banned it, and in early 2025 federal authorities announced plans to place 7-hydroxymitragynine – a potent semisynthetic derivative – under Schedule I. Although framed as targeting concentrated synthetic products rather than the plant itself, the move adds complexity to kratom's already contested status.[100]

Elsewhere, kratom is fully illegal in Australia under the country's restrictive scheduling system, while New Zealand allows it with a medical prescription. In Europe, at least 12 countries have controlled kratom.[101] According to the German Federal Institute for Risk Assessment, kratom preparations are likely to be treated as unauthorised or unsafe novel foods in the EU, limiting their legal marketing. Several EU countries, including France, explicitly prohibit purchase and possession.[102]

Amid concerns about kratom's health risks and disputed claims of kratom-related deaths in the US, some states have called for its international scheduling. This led the WHO Expert Committee on Drug Dependence (ECDD) to conduct a pre-review of kratom and its main alkaloids in 2021.[103] The ECDD concluded that there was insufficient evidence to warrant a critical review – an essential step towards UN scheduling – and recommended kratom remain under ECDD surveillance, where it has been since 2020.[104]



Women in opium field in Kachin State, Myanmar (SKT)

6. Discussion and Conclusion

The previous chapters have traced how drug markets in Southeast Asia adapt and endure across time, substances and borders, and how policies shape – and often worsen – their impacts on people's lives. This final chapter revisits several cross-cutting themes and dilemmas, before outlining ways forward. In particular, it highlights: (1) common structural drivers across opium, ATS, cannabis and kratom markets; (2) patterns of agency and resilience among people who use and produce drugs; (3) the central role of inequality in structuring every level of the market; (4) the ways formal and informal governance shape drug economies; and (5) the systematic failure of prohibition to achieve its stated goals.

The inevitable political nature of drug market studies

Drugs have always been part of societies. Patterns of production, trade and use can be seen over time and across locations, and drug markets are unlikely to disappear as long as humans seek energy, income, pleasure or relief through the use of psychoactive substances. As discussed across this report, attempts to understand these markets only through statistics on volumes and profits offer, at best, a partial picture.

Estimates of cultivation, production or seizures are often treated as neutral indicators of the "seriousness" of drug problems and as benchmarks of policy success. In practice, they are political artefacts. Choices about what is measured, with which methods and by whom, are shaped by institutional interests. In Southeast Asia, most governments work closely with UNODC on data collection and analysis, thereby marginalising community-led research and analysis, such as that carried out by amphetamine user groups or the Myanmar Opium Farmers Forum, as well as various local CSOs in the region.

Such indicators also say little about lived realities: why people turn to opium, methamphetamine, cannabis or kratom; how

they manage risks; or how policies affect their health, livelihoods and safety. They rarely capture the agency of people who use or produce drugs, including the harm reduction strategies they develop, as documented in earlier chapters.[1]

Moreover, the illicit nature of markets makes accurate quantification extremely difficult.[2] Satellite imagery and field surveys for opium poppy provide only rough estimates, given variations in yields, cultivation methods, seasons, quality, number of harvests and farmers' strategies to evade detection. Synthetic drug production is even harder to measure: ATS labs are mobile, use legally traded precursors, and production is inferred from partial seizure data. Wastewater analysis and occasional use surveys can offer useful complementary information, but they too have serious limitations and cannot capture who is using, in what conditions, and with what consequences.

The emphasis on short-term indicators, such as hectares eradicated, kilos seized and arrests made, obscures the structural drivers that keep drug markets resilient: protracted conflict, land dispossession, unequal development, labour exploitation, lack of decent work, weak or abusive governance, armed conflict, and the ongoing demand for psychoactive substances. As argued throughout this report and in previous TNI work, meaningful evaluation of drug policy should be anchored in longer-term development and rights-based indicators: poverty and wealth distribution, food security, the right to land including customary tenure of ethnic communities, recognition of local traditions and customs, access to health, education and justice, gender equality, and reductions in violence and corruption.

The resilience of drug markets in times of COVID-19 and beyond

The Covid-19 pandemic generated some of the tightest controls on movement in recent history. Borders, ports and airports closed, trade slowed, and internal mobility was restricted. Yet, as shown in the opiates and ATS chapters, drug markets



'No Drugs' banner at temple in Thailand (TNI)



Sign at cannabis shop in Bangkok (TNI)

proved remarkably resilient. Respondents across the region reported that heroin, methamphetamine and other substances remained available, albeit with temporary price spikes and quality declines. In Yunnan, some people substituted heroin with alcohol or pharmaceuticals; others shifted toward other more accessible stimulants.

If even pandemic-level border closures could not significantly suppress supply, it is unrealistic to expect that more funding for law enforcement or new trade agreements – which in practice expand the volume of goods crossing borders and thus opportunities for concealment – will substantially change these dynamics. The core assumption of the international drug control system, that production and trafficking can be suppressed to the point of elimination, needs to be re-examined.

This report makes a strong case for the need to develop new and better drug policy indicators. In recent years, Southeast Asian drugs markets – rather than shrinking – have further expanded and diversified. The picture is no longer one of "opium giving way to ATS", but of layered and overlapping markets. Opium and heroin remain vital for many rural communities, both as income and medicine, while methamphetamine pills, crystal meth and newer cocktails have spread across urban and rural settings alike. Polydrug preparations – such as "happy water" in Myanmar and Thailand – illustrate this trend: powders sold under innocuous names that in practice combine ketamine, methamphetamine, MDMA, benzodiazepines and caffeine.

These innovations show how quickly producers and sellers adapt to enforcement and scheduling decisions. When particular substances are banned or heavily targeted, they often re-emerge in new forms, markets or combinations. The shift from pharmaceutical amphetamines to methamphetamine in Thailand after 1979,[3] or from traditional opium smoking toward heroin injection in parts of Myanmar,[4] are earlier examples of this pattern. Today, similar dynamics are visible in the proliferation of new synthetic stimulants, alternative precursors and online retail channels. Social media, encrypted messaging apps and e-commerce platforms increasingly facilitate advertising, ordering and delivery, especially in urban areas.

Diversifying needs for harm reduction in Southeast Asia

In Southeast Asia, harm reduction is referenced in national policy documents in Cambodia, Indonesia, Malaysia, Myanmar, the Philippines, Thailand and Vietnam.[5] Yet this support remains largely tied to HIV/AIDS, hepatitis C and related programming, with services focusing on people who inject drugs – primarily needle and syringe programmes (NSP) and opioid agonist therapy (OAT). Women and other less visible groups have very limited access. These measures are essential, but they represent only a narrow slice of what harm reduction can encompass.

In practice, harm reduction covers a much broader spectrum of approaches that can be adapted to different substances, modes of use and social contexts. It is grounded in the idea that drug use – like other activities involving risk – is part of human life, and that priority should be given to reducing harms rather than pursuing unrealistic goals of elimination. While some services already exist in Southeast Asia (NSP, OAT, condom distribution, sexually transmitted infection (STI) services and, in Myanmar, peer-to-peer naloxone),[6] others remain largely absent: drug consumption rooms, drug checking services and legal prescription for heroin or stimulants. Limited funding and predominantly punitive drug policies keep most people who use drugs within the criminal sphere and away from services. Mandated treatment is sometimes offered as an alternative to punishment, but these programmes often lack evidence and carry significant risks of abuse.[7] In fact, coercing people into treatment – especially in detention – is not only often ineffective but in itself already a form of human rights violation.

Despite these gaps, people who use drugs are far from passive.[8] Across the region, they develop their own harm reduction strategies. As this report shows, in Mon State, Myanmar, information on kratom cocktails has led to safer practices, including avoiding mixing with potent substances, as reported by local civil society groups. People who use methamphetamine commonly share self-regulation techniques – setting limits, avoiding use in negative moods, looking after personal hygiene, staying hydrated, eating and sleeping properly.[9] Similar practices are reported among people who use crystal methamphetamine in Indonesia, where community members distribute safer-use kits (foil, lighter, straws and information, education and communication materials), support mental health care, and provide informal legal aid.[10] Comparable models exist in Vietnam, with strong collaboration between peers, civil society organisations, and academic partners.[11]

In recent years, gender-responsive and intersectional initiatives have become more visible, led by women and LGBTQ people, including sex workers and people who use drugs – often in impoverished and criminalised contexts. Organisations such as Suar Perempuan in Indonesia, Health Opportunity Network in Thailand, IDUCARE in the Philippines,[12] and the Sex Workers in Myanmar network, have developed decentralised models of support. Their work ranges from legal aid and rights-based advocacy to sexual and reproductive health services, mental health support, PrEP (pre-exposure prophylaxis) access, and responses to gender-based violence. While they may not run drug checking or consumption rooms, they operate as crucial community hubs that integrate harm reduction into broader struggles for health, safety and rights. Their approaches are particularly relevant for contemporary ATS use, where harms often stem from socioeconomic pressures and lifestyle factors, including sleep, food intake and demanding work conditions.

Finally, as it has become clear that pursuing a drug-free worlds remains an unachievable objective with many severe negative consequences, it is imperative that harm reduction principles should also be applied to the production side of drug policy. Rather than eliminating opium cultivation, drug policies should aim to reduce the harms related to it. Instead of forced eradication and arresting farmers, policies should support poppy growing communities and address their key problems. This will not only reduce their reliance on opium cultivation, but also contribute to the overall development and safety of these often marginalized communities. More research, discussion and advocacy is needed to further promote this policy concept.

Policy responses that simply "chase the next substance" through bans and crackdowns are unlikely to keep pace with the dynamic trends in the drugs market. Instead, as seen in other regions, pragmatic tools such as drug checking services, early warning systems and tailored harm reduction responses to stimulant and polydrug use will be more effective to reduce drug related problems in communities and keep them safe and healthy. Yet such approaches remain largely absent – and in some cases politically taboo – in Southeast Asia.

Prevailing inequalities and injustices

Throughout this report, we have seen how drug markets are intertwined with broader structures of inequality and injustice. The harms associated with drugs rarely arise from substances alone; they are shaped by who is using, under what conditions, and how states and societies respond.

At every stage of the market, those with the least power are the most exposed to risk. Farmers and small-scale traders are far more likely to be arrested or see their crops eradicated than those controlling finance, logistics or protection. People sentenced to death for drug offences in the region overwhelmingly come from poor and marginalised communities, often playing minor roles in the trade.[13]

In addition, people who use drugs are far from a homogeneous group. Some use heroin to manage pain in the absence of accessible healthcare; others take methamphetamine or kratom to cope with long, poorly paid shifts in plantations, factories, fisheries, construction sites or entertainment venues. As described in earlier chapters, working-class users – including migrant workers, sex workers and informal labourers – often consume drugs to meet basic survival needs: staying awake, tolerating abuse, enduring harsh physical work, or managing trauma. Their options for risk reduction are limited by poverty, criminalisation and stigma.[14]

By contrast, wealthier users can more easily purchase higher-quality drugs, use in safer settings, and access private healthcare or legal advice when things go wrong. In the same KTV bar or nightclub, methamphetamine can signify a coping mechanism for waitresses, sex workers and staff, and a leisure accessory for affluent clients. The same substance thus reinforces existing power imbalances: one person's pleasure or status marker is another's precarious survival tool.

Gender and sexuality intensify these inequalities. Women and non-binary people who use drugs in Southeast Asia face heavier stigma, lower family support and greater exposure to violence than men. Research in Indonesia and the Philippines documents routine police violence, sexual extortion and lack of legal aid for cis and trans women who use drugs.[15] In Myanmar, women in opium-growing areas shoulder extra unpaid labour and must often negotiate with armed actors at checkpoints, while having limited say in political or household decision-

making. For women who inject drugs, cumulative experiences of intimate partner violence, police abuse and childhood trauma significantly magnify overdose risk, as highlighted by studies discussed earlier.[16]

At the same time, rigid gender norms also harm men, including those who do not conform to dominant models of masculinity. In some contexts, pressure to remain "strong", unemotional and in control pushes men toward alcohol and other drugs as a socially accepted outlet. For young male sex workers in the Philippines, drug use can become a way to manage the psychological tension between economic necessity and norms that devalue their work and sexuality.[17] In rural areas, many communities turn to opium or other illicit crops after losing access to land and natural resources. Opium farming may be one of the few available strategies to cover basic needs such as food, health care, schooling or debt repayment. In urban and borderland economies, low-level drug selling often plays a similar role, providing income in the absence of secure employment. In

State sanctioned and extrajudicial killings as disproportionate punishment

In 2009, Malaysian national Nagaenthran Dharmalingam was arrested in Singapore for carrying 43 grams of heroin – an amount exceeding the threshold that mandates the death penalty. Despite evidence of his intellectual disability (IQ 69)[18] and public outcry, he was hanged in April 2022 after more than a decade on death row.[19] His case illustrates how Southeast Asia's harshest drug laws routinely target individuals with socioeconomic vulnerability and limited agency.

According to Harm Reduction International (HRI), hundreds of people are executed every year for drug offences, with Southeast Asian countries among the most prolific users of capital punishment.[20] New death sentences continue to be issued across the region despite the lack of evidence that executions deter drug trafficking,[21] and despite clear human rights arguments for abolition.[22] While Malaysia has recently removed mandatory sentencing of the death penalty,[23] Singapore, Indonesia, Vietnam, Myanmar, Thailand and Brunei continue to allow capital punishment in law.[24]

The principle of proportionality is routinely ignored. Punitive frameworks typically rely on drug quantity as the key determinant of severity, conflating possession for use and low-level distribution with meaningful participation in trafficking networks. Factors such as coercion, economic hardship, mental-health conditions or negligible financial gain are rarely considered, even though most people arrested for drug offences occupy the lowest rungs of the drug supply chain.

Beyond legally sanctioned executions, the same punitive logic fuels extrajudicial killings, disappearances, torture,[25] and other abuses that treat the lives of people associated with drugs as disposable. The Philippines represents the starkest example: human rights organisations estimate that tens of thousands of people were killed during Duterte's "war on drugs", overwhelmingly from poor urban communities.[26] Although President Marcos Jr. has pledged a less violent approach, killings have continued since 2022,[27] and public support for punitive tactics remains high.[28] In Indonesia, civil-society groups reported nearly 200 drug-related police shootings in 2018 alone, though updated data remain scarce.[29]

Myanmar, overlaps between cultivation and selling are growing, as farmers in some areas receive payment in pills and are pushed into small-scale distribution, with high legal risks but limited financial gain.

Even where reforms are introduced, inequalities persist. Thailand's cannabis boom after 2022 opened opportunities for some community enterprises and patients, but it also attracted capital-rich investors and foreign actors who quickly came to dominate lucrative segments of the market. Small farmers and low-income users struggle to compete or navigate complex regulations, illustrating how legalisation without social safeguards can reproduce familiar patterns of exclusion.

These dynamics reinforce a broader conclusion: prohibition does not simply "control drugs". It organises and justifies who is policed, who is punished, and whose lives are considered expendable.

Drugs and conflict

Challenging the dominant "drugs and conflict" narrative

Discussions about the relationship between drugs and conflict often revolve around the assumption that illicit drug markets fuel violence and instability.[30] This dominant narrative tends to frame drugs as a primary driver of conflict and criminality, emphasising how armed groups link up with organised crime networks and fund their activities through drug production and trafficking.

Following this logic, many studies and policy narratives tend to single out specific conflict actors as the main culprits behind a country's drug problems. For policymakers, it is often convenient to blame those labelled as "drug kingpins" or "narco armies", as if these actors operate in a political vacuum, rather than to examine how drug economies are intertwined with broader power structures.



'Drug Treatment Center' of the RCSS (TF)

Drug policies of local authorities and communities

Drug policies are often assumed to be centrally defined and implemented, rooted in national legislation and formal directives. In reality, especially in areas with fragmented or overlapping governance, local authorities and communities frequently interpret and apply policy is highly localised ways. These practices may reinforce, reinterpret or directly contradict national law, depending on local pressures and socioeconomic realities.

In several border areas of Thailand, Myanmar, Bangladesh and China, drug use and sales are so embedded in daily life that "illicit" substances circulate openly with little intervention. Workers in precarious occupations – especially in entertainment economies such as KTV bars and casinos – may be pressured or incentivised to use synthetic drugs to endure demanding work or enhance clients' experiences. Here, the primary issues are not over-policing but the absence of labour protections, healthcare access and safeguards against exploitation.

This contrasts with countries such as Indonesia, the Philippines or Vietnam, where punitive measures, mass incarceration, harsh sentencing and extrajudicial actions dominate local drug governance. Civil society efforts in these contexts often focus on reducing criminalisation, expanding harm reduction and challenging stigma.

In conflict-affected regions like Myanmar, the lack of state services and the severity of drug-related harms have driven communities to take matters into their own hands (see Opiate chapter). This has included forced rehabilitation, conscription of young drug users into local armed groups, poppy eradication and some violent grassroots anti-drug campaigns – responses that often violate human rights norms,[31] but emerge from failing state policies, desperation and the absence of viable alternatives. While harm reduction initiatives exist in some of these areas, they are frequently donor-driven and designed externally, with limited community participation. As a result, programmes may not reflect local political realities or respond to community needs for agency in addressing drug-related challenges.[32]

In addition, many parts of Myanmar are controlled by a wide range of ethnic armed organisations, opposing the military regime. Many of them control significant territory with substantial populations, and have managed to expand these since the 2021 coup, including strategic areas along Thai and Chinese borders. Several of these organisations have developed their own drug policies in order to address increasing drug use, production and trafficking related problems. As drug availability and use further spreads among young people in these areas, these is growing community pressure among these armed groups to "take action". As a result, some armed groups have adopted punitive approaches, including arresting drug users and putting them in forced treatment centres, or sometimes forcibly recruiting them in their armies. However, at the same time, some of these armed groups have learned from previous experience and taken more pragmatic approaches.

Therefore, in several cases, these local actors are not only implementers but often key innovators. Some new policy approaches are being piloted not by central governments but by local authorities – including several ethnic armed organisations – alongside civil society, health workers and community groups. The New Mon State Party drug policy is one such example. Developed in collaboration with Mon civil society and

diverse community stakeholders, it "emphasizes health care for users, prevention of side effects, rehabilitation, and aims to reduce the health, social, and corruption-related harms arising from drugs."[33]

The Karenni drug policy, adopted by the Karenni State Consultative Council in July 2025, is a comprehensive policy covering the needs of opium farmers, people who use drugs, youths and other vulnerable groups affected by drug related issues. It aims to address drug problems in a solution-focused approach rather than implementing harsh punishment. Its basic principles emphasise proportionate sentencing. The policy stresses that there should be sustainable, alternative livelihoods in place for the farmers, the provision of necessary resources and technical support, and the achievement of stable markets for alternative crops. For people who use drugs, the policy stipulates a comprehensive approach of prevention, harm reduction, treatment and rehabilitation. These programmes should be based on the rights and dignity of users.[34]

For its part, the Restoration Council of Shan State (RCSS) draft drug policy prioritises development-led approaches to reduce poppy cultivation, and refrains from forced eradication. According to the RCSS: "to reduce drug-related challenges effectively, we must prioritise conflict resolution and political stability, paving the way for meaningful and durable solutions."[35] The RCSS also conducted a consultation meeting on their draft drug policy with CSOs from Shan State.

These examples illustrate that while local authorities can enforce repressive responses under pressure, they also possess the capacity to experiment with more pragmatic, health- and rights-based alternatives, and develop policies in cooperation with local communities and CSOs, reflecting local realities and needs while incorporating international best practices and lessons learned. However many challenges remain, and further support is needed to improve these policy initiatives and their implementation.

Similarly common is the attribution of drug problems to political opponents and/or marginalised groups. Rather than resolving tensions, such accusations risk reinforcing divisions and fuelling conflict.[36]

Such narratives also ignore the fact that in several countries the drug trade comes dangerously close to the upper echelons of power. It is important to stress that corruption and involvement in the drug trade by authorities is not only a problem in unstable countries with large drugs production such as Myanmar, but also in neighbouring countries.[37]

These narratives may make compelling stories yet ignore more complex and deep rooted political issues at the core of a conflict, or structural conditions that sustain drug economies. Rather than analysing why certain armed movements exist (for example by examining their grievances or aspirations), mainstream accounts tend to focus narrowly on their involvement in drug production and trafficking. While such involvement cannot be denied, it tells only part of the reality. It also risks absolving powerful actors who benefit from the drug trade while leaving poor communities trapped in a cycle of dependence on drug or other economies for survival, yet suffering most from the violence, displacement and dispossession linked to conflict.

Meanwhile, different armed groups or movements have different levels of involvement and relationships with drug and other illegal economies. In some cases, different armed groups have varying and

sometimes opposing drug policies. Some are restrictive or prohibitionist (arresting drug users or eradicating illicit crops), others more tolerant and permissive (offering protection, taxing or turning a blind eye to production). Given the overlapping or disputed territorial control among these groups, such divergent approaches to drug markets can themselves become sources of tension and conflict.

In addition to the "drugs fuel conflict" narrative, many studies remain focused on the argument that the expansion of drug markets and problems is driven by the supposed absence of "rule of law" in conflict-affected areas such as Myanmar. Yet similar patterns are visible in comparatively stable settings like Thailand. The issue is not only a lack of rule of law, but also the quality of governance and the nature of the laws themselves.

Myanmar as a case in point

The nuanced relationship between drugs and conflict in Myanmar illustrates the limitations of the conventional claim that drugs fuel conflict (and vice versa),[38] as well as the recurring argument that certain armed movements are to blame for the drug trade. Three main points can be made in this regard.

First, decades of conflict in Myanmar are rooted not in drug markets but in longstanding economic, ethnic and political grievances, including land dispossession, inequality and struggles for autonomy. Drug production and trade become entangled with these conflicts over time, and so do other economic sectors – from logging and mining to the entertainment sector. Any analysis of the links between conflict and these economies remains incomplete without addressing the deeper injustices that cut across all sectors and sustain inequality.

Second, Myanmar's drug market is significantly less violent than other countries long affected by conflict and drug markets, such as Mexico or Colombia. Unlike in countries with high levels of violence between cartels, security forces and armed groups, many armed and criminal actors in Myanmar have long prioritised stability over confrontation, recognising that the absence of direct violence or warfare is more conducive to ensuring the flow of trade and profit. Such criminal actors, who are not only



'Narcotics Drugs as the main central enemy' Pat Jasan signboard on Kachin State (TNI)

involved in the drug trade but also in other illicit businesses – such as wildlife trade, car smuggling, illegal mining and logging, and scam operations – greatly benefit from the status quo and Myanmar's political turmoil. But they prefer ceasefires and working with militia groups allied to the Myanmar army, rather than working in active and violent conflict areas. There are most likely also informal agreements or understanding between conflict actors on drugs production and trafficking from which all sides benefit. A more violent drugs market would therefore, in their eyes, be bad for business.

Third, for the Myanmar Army the priority is security, not drug control. Currently, most ATS production in Myanmar takes places in areas controlled by Myanmar army-backed militias and Border Guard Forces and some armed groups that have a ceasefire with them. These areas are relatively stable, and allow for large scale production of amphetamine pills. It is also much easier to smuggle in ATS precursors and smuggle out ATS pills from such areas into central government-controlled territory. Therefore, they will not take any actions against these groups, and they protect them from action by others. However, when such groups outlive their political usefulness, the Myanmar army is quick to shift its allegiances.

Fourth, although Myanmar's drug markets are comparatively less violent, this relative stability should not be mistaken for peace. Beneath the surface, repressive drug policies continue to deepen existing inequalities and tensions, particularly in rural areas where opium cultivation and related small-scale trade remains a key livelihood strategy. Eradication campaigns and harassment continue to target poor farmers while leaving powerful actors untouched.

As elsewhere, the role of drug policy itself, and its capacity to worsen conflict, is frequently underestimated. Measures such as crop

Experiences of sex workers who use drugs in Myanmar

In Myanmar and elsewhere, women, men and non-binary people engage in sex work to support themselves and their households. Alongside economic survival, sex worker collectives have long called for human rights protection, access to health care, and policy reform.

Sex workers use drugs for varied reasons. Many rely on methamphetamine to sustain long working hours, cope with demanding or unsafe clients, or manage pressure from partners or customers. Others use sedatives to ease physical or emotional pain linked to work, relationships or past trauma. Drug use can also be social or recreational. As a 48-year-old female sex worker in Yangon noted in August 2024, "sometimes when we gather, we use drugs not for sexual purposes, but simply for recreation."

Stigma and punitive laws compound the challenges sex workers face, and drug use often intensifies that stigma. The same respondent described being judged even for smoking or drinking, and noted that discrimination frequently comes from families themselves: "My friend faced that kind of treatment even from her own family. Sometimes, families themselves are neither good nor supportive. Yet we still have to work, earn money and send it to them."

Sex workers who use drugs thus navigate overlapping layers of precarity (criminalisation, gendered stigma, and limited access to health and social support) shaping their vulnerabilities as well as their strategies for survival.



Bar in Bangkok (TNI)

eradication, opium bans or the criminalisation of low-level drug selling and use only further weaken communities. By depriving families of income, punishing young people for drug use, or spreading fear through arrests, repressive drug policies create conditions ripe for resentment, exploitation and division. They also intensify stigma. Links with drugs – even when it is as minor as drug use – become a justification for punishment and exclusion, reproducing conflict not only between armed actors but also within homes, schools, clinics and other day-to-day contexts.

Finally, the large scale availability of drugs on the Myanmar market has also led to a problematic drug use among young people. This has caused several community leaders and organisations, especially in ethnic regions, to accuse the Myanmar government of using drugs as a "weapon of war" against ethnic communities, thereby fuelling the current conflict. As related by a representative of a Kachin CSO: "More Kachin people have died of drug-related problems than because of armed conflict."[39] In an attempt to counter this threat to their communities, Kachin church leaders initiated a strict anti-drugs campaign, which later grew into the Pat Jasan movement (see Opiate Chapter). According to one of its leaders:

> "The drug issue is made worse because the military uses it as a weapon. They are fighting the Kachin people with drugs as well as bullets, keeping people addicted."[40]

However, repressive and violent drug policies can also have negative repercussions on conflict. Ironically, the heavy-handed anti-drugs crusade of the Pat Jasan movement in Kachin State has fuelled ethnic tensions in the region. Pat Jasan members have not only arrested Kachin drugs users but also those belonging to young members of the ethnic Shan community, and subsequently put them in Pat Jasan drugs detention centres or even KIO jails. This has increased existing resentment among local Shan communities, who see Pat Jasan as a Kachin ethnic political

movement. In response, the Myanmar army approached some of these Shan communities in Kachin State, offering them weapons and support to "defend themselves against Pat Jasan and the KIO".[41] In addition, in 2016, violence erupted between opium farmers, a Kachin militia group and a group of some 3,000 Pat Jasan members, when the latter tried to eradicate their poppy fields.[42]

Drugs and Peace

Recognising how drug policy can fuel conflict also opens space to imagine how it might support peace. In Myanmar, drug issues have already served as an entry point for dialogue between ethnic armed organisations, community groups and civil society actors. Bringing people and organisations from different backgrounds together around drug policy discussions can help improve mutual understanding and cooperation, for instance between different ethnic communities in Myanmar. While repressive drugs policies often contribute to conflict, as we have seen above, drug policies that promote cooperation and focus on providing services and assistance to communities, such as development, health and education, can lead to positive outcomes, and can help promote peace and stability instead.

Where discussions are grounded in independent research and respect for affected communities, they can help build shared understanding of what the "drug problem" actually looks like on the ground and explore alternatives to eradication and mass incarceration.

In principle, drugs should continue to be included in future political dialogues, not as a weapon against opponents but as a shared concern that requires cooperation on development, health and justice.



Farmers working in poppy fields in southern Shan State (TNI)

Final conclusion and recommendations

Across mainland and maritime Southeast Asia, borderlands and urban centres alike, drug markets have expanded and diversified despite decades of prohibition. A once predominantly opium- and heroin-centred economy now coexists with booming ATS production, increasingly complex synthetic cocktails, and renewed interest in cannabis and kratom. These shifts do not mark a simple transition from "old" to "new" drugs, but rather a more intricate, layered and polydrug landscape.

Common drivers run through this diversity. Long-standing armed conflicts and militarisation, land loss and precarious rural livelihoods, unequal access to health, education and justice, exploitative labour conditions, and the enduring demand for psychoactive substances for assorted purposes – all such factors sustain drug economies. Formal and informal governance – from village authorities and ethnic armed organisations to police, militias and business networks – shapes who benefits, who is harmed, and whose actions are criminalised.

These patterns cut across geography. In mainland borderlands such as northern Myanmar, Laos and northern Thailand, opium, ATS and cannabis markets are intertwined with conflict, displacement and infrastructure projects. In maritime Southeast Asia, cross-border maritime routes, plantation economies and migration corridors underpin markets for heroin, ATS, cannabis and kratom. In large cities such as Bangkok, Yangon, Kuala Lumpur and Manila, nightlife and service economies are key sites of both consumption and enforcement. Yet the same themes recur: inequality, informal governance arrangements, and the resilience of markets under pressure.

Looking ahead, several trends are likely to intensify:

Polydrug and synthetic markets will continue to prevail and diversify, with more mixtures like "happy water", new synthetic stimulants and opioids, and shifting precursor chains.
Online and app-based markets will expand, particularly among younger and urban populations, complicating traditional enforcement tools.

Prohibition-based enforcement will likely continue to produce balloon effects, displacing challenges across substances, geographies, patterns of consumption and livelihoods.

Climate change, economic crises, conflict and political upheaval may further push communities into risky livelihoods, including illicit cultivation and low-level drug selling.

Medical and wellness markets for substances such as cannabis and kratom may grow, raising questions about who benefits and who remains criminalised.

Other illicit activities, such as online scamming, illegal gambling and trafficking networks, may increasingly overlap with drug markets amid rising inequality and failing prohibition policies.

In light of these realities, the central lesson of this report is clear: prohibition, as implemented to date, systematically fails on its own terms while deepening inequality and harm. The question is no longer whether markets can be eradicated, but how policies can be reshaped to reduce risks, protect rights and support fairer forms of development.

Concretely, a different approach to tackle drug related issues could rest on five interlinked shifts:

Reframe how success is measured

- Move beyond hectares eradicated, kilos seized and numbers of people arrested.
- Use indicators grounded in the Sustainable Development Goals and human rights: reductions in poverty and harmful inequality; improved access to housing, food, health, harm reduction and education; lower rates of overdose, HIV and hepatitis transmission; reduced violence (including gender-based violence)

and corruption; and greater participation of affected communities in decision-making.

Transform knowledge production about drug markets

- Invest in mixed-methods research that combines quantitative data with qualitative, community-based inquiry.
- Support peer-led and farmer-led research initiatives, and ensure that women, LGBTQ+ people, migrants, sex workers and other marginalised groups are not treated as afterthoughts but as central knowledge-holders.
- Support CSOs and local authorities (EAOs and new political structures) to analyse drug related issues in their areas
- Encourage independent monitoring of drug policy impacts, including related to prisons, policing, public health and conflict.

Centre harm reduction and health for all major substances

- Scale up harm reduction beyond opioid-focused services to address ATS, polydrug and alcohol use in both urban and rural settings.
- Pilot and expand pragmatic tools such as drug checking, early warning systems, non-coercive treatment options and low-threshold services that respect privacy and autonomy.
- Ensure that access to treatment and support is voluntary, non-punitive and compatible with people's daily realities, including irregular work and caregiving responsibilities.

Address structural inequality in and through drug policy

- Recognise that drug use, cultivation and low-level trading are often survival strategies under conditions of land loss, debt, unsafe labour and gendered expectations.
- Link drug policy reforms to broader efforts to secure land and resource rights, strengthen labour protections, expand social protection, challenge harmful gender norms, and remove discriminatory laws
- Ensure that any legal regulation of cannabis, kratom or other substances includes strong equity measures – such as support for small producers, community enterprises and people with prior criminal records – so that benefits do not accrue solely to large investors.

Rethink the relationship between drugs, governance and peace

- Shift away from militarised and punitive approaches that treat drugs as a convenient justification for coercion.
- Support local and national dialogues on drug policy that bring together ethnic armed organisations, civil society, user groups, farmers and authorities, building on experiences described in Myanmar and elsewhere.
- Promote models of regulation and local governance – such as community charters and negotiated cultivation schemes – that prioritise health, livelihoods and environmental sustainability over short-term displays of "toughness".

Taken together, these shifts point toward a more realistic and humane vision: one in which drug policies are designed not to wage symbolic "wars", but to expand people's capacity to live safe, dignified and self-determined lives. Drug markets will continue to change; the real test is whether policy can evolve away from fear and punishment toward justice, care and collective resilience.



Members of the UWSA in poppy field before the opium ban (TNI)

End Notes

1. Introduction

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3. The ATS Boom and Diversification of Synthetic Substances

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178. Interview with a 27-year-old gay man working as an event staff in Thailand, March 2022.

179. Interview with male office worker in Bangkok, self-identifying as gay, January 2021.

180. Additional information of social profiles showing that indicate that user is a crystal meth or 'Ice' user-In Thailand, drug users are mostly indicate on their social profile status with related emojis/symbol such as 'snowflake ❄', 'syringe 💉', 'airplane ✈', 'ice skate ⛸', 'ice cube 🧊', 'fuel pump ⛽', 'sweat droplets 💦', 'cool button 🆒', 'alembic ⚗', 'cloud with snow 🌨', 'cloud ☁' and many more in terms of text which can be translated as 'hi', 'high fun', 'chem sex', 'chem fun', 'chem', 'pnp', 'cloud', 'slam', 'meth slam', 'fly', 'high fly', 'refuel', 'add-up', 'extra fuel', 'party and play', 'fire', 'shabu', 'boiling pot', 'potting', 'puffing', 'boiling', 'bubbling', 'geared up', 'spun out', 'spinning around', 'speed', 'dunk', 'tina', 'Crank', 'twisters', 'zooming' and many more, explained by a gay/pan-sexual person who uses drugs in Bangkok.

181. Interview with person identifying as gay/pan-sexual in Bangkok, Thailand, January 2021.

182. Interview with masseur identifying as gay, Nonthaburi, Thailand, January 2021.

183. Interview with a 19-year-old woman in Thailand, January 2021.

184. "Alkyl nitrites, commonly known as poppers, are potent, short-acting, rapid onset inhalants that produce a brief warm sensation, head rush, relaxation of smooth muscle tissue, and euphoria. The first alkyl nitrite to be developed, amyl nitrite, was prescribed therapeutically for the management of chest pains, in the 1860's. They became popular in the 1970's disco scene, starting the more widespread use of the drug. Nowadays they are mainly used in the context of sexual encounters, but sometimes also in social settings, dance clubs, and music festivals." Read more: Drug Science, "Alkyl Nitrites (Poppers)", https://www.drugscience.org.uk/poppers

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187. The presentation reports that happy water is a kind of mixed liquid containing methamphetamine, amphetamine and ketamine. "Fairy water" mixes MDAM, Nimetazepam, Codeine together.' Read more: China National Narcotics Control Commission, "Country Presentation for Global SMART Programme Meeting for East Asia", Bangkok, Thailand, 29-31 July 2009.

188. CVGTN, "Popular beverage 'Happy Water' banned by China's FDA as intoxicant", 5 October 2017. Gamma hydroxybutyrate (GHB) is a type of depressant.

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191. Interview with Bamar male former Myanmar Army soldier, August 2024.

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6: Discussion and Conclusion

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Comparable framings are also common in European security discourse. For example, Europol states that drug trafficking acts as "an additional destabilising factor" in countries already facing political, social, health, and economic crises. See: Europol, "Trade in illicit drugs", https://www.europol.europa.eu/crime-areas/trade-in-illicit-drugs.

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32. See for example: Dan S L, Mahan J H P, Sadan M & Meehan P, "The Pat Jasan drug eradication social movement in Northern Myanmar part one: Origins & reactions", International Journal of Drug Policy March 2021, 89(4):103181.

33. As shared by the Mon Drug Policy Team in July 2025 several months after the Mon drug policy was adopted by the New Mon State Party. See also: Monnews, "Mon Drug Policy Launched in News Mon State Party – Controlled Areas", 27 January 2026.

34. Karenni State Consultative Council, "Karenni State Interim Drug Policy", 19 July 2025, https://ieckarenni.org/karenni-state-interim-drug-policy/.

35. Restoration Council of Shan State, "Statement on International Day Against Drug Abuse and Illicit Trafficking", 26 June 2025, https://english.taifreedom.com/statement-on-international-day-against-drug-abuse-and-illicit-trafficking/.

36. The 2018 Myanmar Opium Survey by the UNODC, for example, brings about specific accusations against certain conflict actors, and in so doing oversimplifying the complex realities on the ground. Read more: TNI, "A Distortion of Reality".

37. Hasson, J. & Hoyle, C., "Thai Drug Offenses and Narcotic Charges: Tracing Thailand's Drug Control and Capital Punishment History", Brooklyn Journal of International Law, Vol. 49, Iss. 2, 2024; Aspinall, E. & van Klinken, G., "The State and Illegality in Indonesia", January 2011.

38. Regina de Luna & Emily Chan, "Myanmar civil war fuels flourishing drug trade in northern Thailand", South China Morning Post, 15 March 2026.

39. TNI Commentary, "People's War on Drugs in Kachin State: Indication of Failed Policies", 21 March 2016.

40. Interview with Ahgu Khin, steering committee secretary of the church-based anti-drugs organisation Pat Jasan, quoted in: David Shaw, "Drugs and bullets in Myanmar", Al Jazeera, 8 February 2017.

41. Interview with representative of Shan community in Kachin State, Myitkyina, March 2013.

42. BBC News, "Clashes erupt in north Myanmar over opium poppy fields", 25 February 2016.

Despite decades of repressive drug policies, Southeast Asia's drug market has only expanded and diversified. Amphetamine-type substances become increasingly prevalent, whilst opium cultivation and opiate markets persist in parts of the region alongside emerging substances like "happy water." Prohibitionist approaches often produce the "balloon effect," simply displacing markets, while undermining access to public services and human rights protection.

Gathering accurate data on drug markets remains challenging, and community involvement is essential for developing effective development, harm reduction and public health strategies. Though prohibitionist policies remain the most dominant approach, there have been examples of softening attitudes: cannabis and kratom reforms in Thailand, civil society led harm reduction programmes in Vietnam and Indonesia, and reductions of punishment by local governance actors in parts of Myanmar.

In large cities such as Bangkok and Yangon, nightlife and service economies are key sites of consumption, enforcement, and survival. Despite their different contexts, the same themes often recur: repressive policies tend to harm those living on the margins, worsening inequalities and undermining social cohesion. While conflict actors in countries like Myanmar engage variably with drug trafficking, there are also opportunities for cooperation and coordinated drug policy responses that benefit communities through healthcare, social support, and democratic governance.

This report documents changes in drug markets in Southeast Asia and the wider region and analyses how they interact with social, economic, and political dynamics. Noting the limitation of quantitative data, the report highlights key insights from voices commonly sidelined in mainstream policy debates, namely those of people who use drugs, farmers and traders, as well as activists. The report calls on all actors in the region to reform existing drug policies, to ensure that they are evidence-based, support affected communities, adhere to human rights, and focus on providing development and services to those in need, instead of punishing them with harsh and oppressive policies.



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